

OCD NEWSLETTER



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FROM THE FOUNDATION

Dear Readers,

Well, I've been through the ultimate OCD experience and all the while I've been on medication! We decided that since we've expanded the Annual Conference we had to change the design of the brochure and the layout. I didn't realize it was going to be an Exposure and Response Prevention activity. We hired a designer and a printer and sent them thirty typed pages of seminar descriptions, and presenters' affiliations and times and days and registration data and CEU information. We wiped our hands of it after sealing the Federal Express packet and sat down to wait for 20,000 beautifully laid-out and printed brochures. Folded and ready to mail. That was in April. It's the end of May as I write.



The OCF staff and volunteers at the 1999 Conference reception.

Since we sent our little opus away, it's boomeranged back five times. We've proofed and proofed and proofed some more. Some times one person read it and passed it on. Sometimes, one person read out aloud and the other followed with a ruler. One time we sat in our individual offices and pulled our hair out in unison as we each proofed in silence. Then we'd get together and match corrections.

In every proof, we found lots to change. And, I'm the only one with an actual diagnosis. I suppose if we dragged out copies of each of the five versions (so I'm a hoarder; I saved them) we'd find that we eventually changed some changes back to the original.

After our five proofs, there were two more. Supposedly for color and placement. We weren't included in the reviewing team on them. Just the professionals. I'm a little suspicious. I think the printer and the designer decided they didn't need to learn anything more about how someone with OCD handles a proofreading assignment.

Then late in May, the printer called to say, we wouldn't be seeing the finished, ready to mail product until after the holiday weekend unless we were ready to pay triple overtime. She told me this five times. I think we have converted the printer to OCD.

By the time you read this, you'll have received your brochure and registered. I just needed some sympathy.

If you haven't registered, let me tell you what you'll be missing. This year, we're starting on Friday morning because we've got so many great seminars and workshops for you. Over 50. I can't give you the exact count because my therapist has forbidden me to look at the brochure again. He has nightmares that I'm going to be making changes on all 20,000 by hand. There was also some loose talk about how my picture has been circulated to every printer and union shop on the east coast.

This year, aware that many more children and adolescents are being diagnosed with OCD, we recruited therapists and doctors and educators and parents to speak on "Kids and OCD." Tamar Chansky's going to be using her new book, which will be introduced at the Convention, to teach parents how to free their kids from OCD. There's going to be a special support group for parents run by parents on Friday night. D'Arcy Lyness is going to show parents how to use the kids' own creativity to help them through the rough spots. And, there will be workshops on Behavior Therapy for children and adolescents.

For the kids, we have two art workshops and some special events. Terry Spencer Hesser, directly from a stint filming a PBS special on OCD, is going to help the younger kids do their own "Blair Witch"-type project videotaping how they see their OCD. For the older adolescents and twentysomethings, Nate Fields a screen writer from California is going to give a reading of his screen play on

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OBSESSIVE COMPULSIVE FOUNDATION AWARDS FIVE RESEARCH GRANTS

The Obsessive Compulsive Foundation, announced last month the five scientists who have won Foundation research grants. Janet Emmerman, president of the OC Foundation Board of Directors, and Patricia Perkins-Doyle, J.D., executive director, made the announcement. According to Perkins-Doyle the Foundation's Board of Directors made the decision after a subcommittee of the Foundation's Scientific Advisory Board did a review of the proposals submitted.

These awards are given every year to encourage young researchers to concentrate on developing effective treatments for OCD and its Spectrum Disorders.

The grant recipients are: Barbara Van Noppen, MSW, Angell Street Wellness Collaborative; Thilo Deckersbach, Ph.D., Massachusetts General Hospital/Harvard Medical School; Mark H. Freeston, Ph.D., Centre de Recherche Fernand Seguin Universite de Montreal; Beth S. Gershuny, Massachusetts General Hospital /Harvard Medical School; and Robert M. Roth, Ph.D., Dartmouth Medical School.

The grants were awarded to Young Researchers working in the field of Obsessive Compulsive Disorder. These awards are given every year to encourage young researchers to concentrate on developing effective treatments

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Sunday in the Park with OCD. See Page 3

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.

CONFERENCE BULLETIN BOARD



Jeannette Cole, deputy director, with Patrick Johnson, the Art Show's originator.

"ART IS A LIFELINE" EXHIBIT

The Foundation is soliciting art work again this year for the Art Show at the 7th Annual Conference. The theme of this year's show is "Art Is A Lifeline." Commenting on the theme, Jeannette Cole, deputy director of the OCF, stated: "We want to show how art can be salvation or a lifeline to someone who is struggling to cope with OCD for both the artist and the viewer."

Anyone who is a member of the OCF, age is not a factor, can submit up to three pieces, utilizing any medium. Entries should be brought to the registration booth at the Conference and left for Jeannette Cole. All artwork will be returned after the conference.

For more information, call Jeannette at 203.315.2190 or e-mail her at cole@ocfoundation.org. *



Admirer and artist at the 6th Annual Conference Art Show

NO NAME THAT WE LIKE YET BOUTIQUE

The Lancer Family of Long Island will be managing the Boutique that will be sharing space with Daisy's Bookstore at the Conference. Any member of the OC Foundation is invited to display merchandise he or she has made at the Boutique. Along with OCF teeshirts and mugs, we want to sell THINGS made by people with OCD. Our first product is a CD of music written, produced and played by an individual with OCD.

If you have a product that you want to sell at the No Name That We Like Yet Boutique, contact Patricia Perkins-Doyle at 203.315.2194 or e-mail her at pbp2325@yahoo.com. We want to stock and sell items made by members of the Foundation. As stated in the article on the OCF Website, anyone who is a member of the Foundation and has OCD can submit items to be sold at the Boutique. Photos of suggested items should be sent to the OCF office in North Branford, CT, ATTN: Boutique Manager. The manager will notify anyone whose items are accepted for display and sale. The Foundation will receive 15% of the sale price of any items sold exclusive of sales tax. This money will be used to defray the expenses of the Conference. *

OCF ECONOMIC INTEREST CIRCLE

The OFC Economic Interest Circle will make its debut at the 7th Annual Conference in Schaumburg. We will have a full size display board set up in the Registration area at the hotel. Bring business cards, advertisements or index cards that detail what you do: computer processing, consulting, writing, editing, car repair, plumbing. Anyone who is a member of the Foundation can post an "ad". That way attendees can review the offerings to see if something or someone they need is available, and give the advertiser a chance to bid or be interviewed.

If we raise sufficient funding, we can produce a booklet with all the names and products listed and distribute it to OCF members, or reproduce the list on the Website. There would be a slight cost for each "ad" to defray the costs. *

FROM THE FOUNDATION

Continued from page 1

OCD and then he and Rob Lancer, a twenty-something psychology grad student, are going to lead a support group.

For those interested in alternative treatments, the Pollards, Heidi and Alec, are going to discuss herbal remedies and David Shannahoff-Khalsa is going to give a workshop on the use of Yoga in treating OCD and a follow-up session for anyone who wants to try it.

We've got talks scheduled on the spectrum disorders, including body dysmorphic disorder, self-mutilation, compulsive gambling, impulsivity disorders, trichotillomania and compulsive hoarding and shopping. Gail Steketee and Randy Frost are going to take the participants in the compulsive hoarding and shopping workshop on a non-shopping tour of the Woodfield Mall. Nothing like a

little *in vivo* behavior therapy. I'm angling for a compulsive proofreaders workshop.

Friday night, there is going to be a camping trip right in the Hyatt Regency. This is the brainchild of those nature-loving behaviorists from the Philadelphia Affiliate. The warning on the label on this one is that Jon Grayson is the self-same behaviorist that was struck by lightning on one of these trips several years ago.

Ian Osborne is going to talk about Therese of Lisieux, who suffering from scrupulosity long before the advent of behavior therapy, invented her own treatment plan, which has quite a resemblance to what Lee Baer and Fugen Neziroglu and Fred Penzel and Jonathan Abramowitz and Alec Pollard and Lee Fitzgibbons, just to mention a few, are going to be talking about in their workshops during the Conference.

Michael Jenike, although he is overworked, is going to talk about medication and take questions from the audience. And, if your question isn't answered in his workshop, every presenter is doing a stint for "Ask the Experts", so sign up for that.

We've lined up experts on GAD and Panic. Fred Penzel, Tamar Chansky, Bruce Hyman and Cherry Pedrick, Christian Komor and Andrew Morrison are all introducing their new books at the Convention. You'll have a chance to get your copy signed and talk with the authors.

And, there will be a Reception on Saturday night where we're going to raffle off gift certificates, coupons and tickets to local restaurants and amusement parks. The show piece of the Raffle is a hand-made quilt directly from a quilting bee in the Ozarks bought and donated by Edna and Bernie Bahr.

And more. But I have to proofread the Newsletter too, although it's being printed by another printer. The brochure's printer mumbled something about closing up and going into another line of business.

But, before I close remember to do all your compulsive shopping at our new Shopping Mall brought to you by GreaterGood.com (see the article on page 3) and send in your business card for the OCD Economic Interest Circle (see the article on this page). *



SUNDAY IN THE PARK WITH OCD

by: Fred Penzel, Ph.D.

On Sunday, June the 11th, something historic occurred within Long Island's OCD community. You won't have read about it in the papers, and it didn't appear on the evening news, but it was important to us nonetheless. I am referring to a picnic that was held in Eisenhower Park in East Meadow, Long Island, about 40 minutes east of New York City. Obviously, Sunday picnics happen all the time and are usually not a big deal here. But this picnic was the first annual all-Long Island event ever held by and for those with OCD.

were most fortunate to have several noted figures from the OC world, including Patricia Perkins-Doyle and Jeannette Cole who came on behalf of the Foundation (driving all the way from Connecticut), as well as Roy C., founder and guiding spirit of OC Anonymous (who happens to be a local resident). I must also note that this picnic probably would not have happened without the able efforts of Robert Lancer, a soon-to-be psychology doctoral student at Hofstra University, and his generous family.



Long Islanders against OCD cool down after a hot soccer game.

Our purpose was threefold. First, we hoped to create a sense of community among the Island's OC sufferers. We have a few local professionally led meetings and a number of OC Anonymous meetings, but no true focal point. Sadly, downstate New York still lacks an OCF affiliate. This has always amazed me, considering that we have so many sufferers in our area. Second, we wanted to help destigmatize our OCD community. Getting together for a nice afternoon out with other good, caring and intelligent people can go a long way toward not feeling different. Third, we wished to raise some money at the grassroots level for the OCF. The OCF does so much for those with OCD in so many ways including the website, the national conference, the Behavioral Therapy Institute (that trains professionals), the referral list, the publications, the research funding, and the national representation, that we felt it was the least we could do.

Anyway, it was a hot sunny day with a nice breeze, and we had plenty of drinks and snacks. Games were played, people chatted and made new acquaintances. We

When we first planned this picnic, we really didn't know what to expect. No one here had ever done this before. We figured that however it turned out, it would still be a success just because it happened at all. People often talk about doing things, but we were really doing something for a change.

To report on our results, we had over 40 people in attendance and we raised about \$ 600.00 for the OCF Research Fund. In all, not too bad for a first time out. We are already making plans for a bigger and better second annual picnic next year. Many have already offered to help out.

I would like to close by urging you readers out there to do something similar. It doesn't have to be big, expensive, or fancy. All you really need are some picnic tables and a sunny day. The OCF is the only organization that really cares about you so it would be good for all of you to return the caring. It doesn't have to be a one-sided relationship.

One last note. At one point, I stood back in the park and looked over our picnic. You know what? It didn't look one bit different from anyone else's. *

STOP AND SHOP! GreaterGood.com

If you need to buy anything, STOP right now and GO to the OCF Website,

HYPERLINK:
["http://www.ocfoundation.org"](http://www.ocfoundation.org)

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

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

OCD NEWSLETTER

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

FIVE RESEARCH GRANTS

Continued from page 1

In announcing the recipients, Emmerman said: "We are proud to be a part of the search for a cure. Next year with the help of our friends and benefactors we will be able to raise more money to help researchers find treatments that will help everyone with OCD."

Barbara Van Oppen

Barbara Van Oppen, who has a private practice at the Angell Street Wellness Collaborative in Providence, Rhode Island, is also a research associate at Brown University. Van Oppen's proposed study is entitled "Expressed Emotion and Family Accommodation in OCD: Implications for Family Behavioral Treatment."

In discussing her proposal, Van Oppen made the point that her project had its roots in the more than 15 years she has worked with OCD patients and their families. She said: "The family support system often plays a critical role in the prognosis and treatment outcome of patients with OCD." She wants to do this study because "systematic study of family interaction patterns is needed to identify possible psychosocial treatment interventions that will improve clinical outcome." The Foundation's grant for this study is \$18,625.

Thilo Deckersbach

Thilo Deckersbach, Ph.D., who was awarded a \$9,500 grant, has been a Research Fellow in the Obsessive-Compulsive Disorder Clinic and the Cognitive-Behavior Therapy Program at Massachusetts General Hospital since 1997. These programs are run by Harvard Medical School.

Dr. Deckersbach's proposal is entitled "Habit Reversal for Tic-like Compulsions." In describing his proposed study, Deckersbach stated that it "was designed to investigate whether habit reversal treatment significantly reduces tic-like compulsions. The aim of this project is to advance our knowledge about effective treatments for OCD."

It is Deckersbach's hypothesis that the OCD tic-like compulsions are so similar to the complex motor tics of Tourette's Syndrome that habit reversal, which is therapeutic with Tourette's patients, should be helpful with OCD patients who have tic-like compulsions.

This study will be done at the Obsessive Compulsive Disorder Clinic at Massachusetts General Hospital where ten adult patients have already been recruited.

Mark H. Freeston

A grant of \$19,987 has been awarded to Mark H. Freeston, Ph.D.*, of the Centre de Recherche Fernand-Seguin in Montreal, Quebec. His co-investigator is Christo Todorov, M.D.

Freeston's grant proposal is entitled "Cognitive Behavioral Treatment for Obsessive Thoughts Among Adolescents." According to Dr. Freeston, who is an assistant professor of research at the Department de psychiatrie, Universite de Montreal, this study is important for scientific and economic reasons: "Because of the serious long term costs associated with adolescent OCD, it is essential that effective treatment strategies are made available for adolescents troubled by severe obsessions."

For over 9 years, Dr. Freeston has been conducting research aimed at conceptualizing and treating obsessive thoughts within a cognitive-behavioral framework. With the Foundation's grant, he intends to test the efficacy of his cognitive behavioral therapy and then develop a manual and workshops. This will enable him to share this treatment for refractory patients with other clinicians and researchers.

Beth S. Gershuny

Beth S. Gershuny was awarded \$9,750 for her proposal "Lifetime Traumatic Experiences and Post Traumatic Disorder in Patients Seeking Treatment For Obsessive Compulsive Disorder." Gershuny, who has recently received her Ph.D., and is now a fellow at the OCD Clinic at Massachusetts General Hospital, the OCD Institute at McLean Hospital and at Harvard Medical School, stated in her proposal that there is anecdotal clinical evidence that patients diagnosed with OCD who are also suffering from moderate to severe PTSD are frequently non-responsive to current state-of-the-art behavioral and pharmacological treatments for OCD. She says that her proposed study "will attempt to close this gap in empirical information to provide a foundation for the development of improved treatments for OCD sufferers."

Co-investigators on this study are Lee Baer, Ph.D, Massachusetts General Hospital OCD Clinic and OCD Institute, Harvard Medical School, and Edna B. Foa, Ph.D., Center for the Treatment and Study of Anxiety, University of Pennsylvania Hospital and Medical School.

Robert M. Roth

Robert M. Roth, Ph.D., of Dartmouth-Hitchcock Medical Center won an OCF grant for his study "Functional MRI Activity and Inhibition in OCD."

Dr. Roth, who is currently a Neuropsychology Fellow at Dartmouth Medical School, has been involved in research on the electrophysiology of response inhibition and predicting responsiveness to pharmacological and cognitive-behavioral treatment in OCD for some time now. His mentor on this project is Andrew J. Saykin, Psy.D, ABPP-CN, an associate professor of Psychiatry and Radiology at Dartmouth Medical School and director of the multidisciplinary Brain Imaging Laboratory.

Dr. Roth's proposed research will involve using state-of-the-art brain imaging technology to evaluate activity in the cortico-striato-thalamo-cortical (CSTC) circuitry while adults with OCD complete certain visual tasks. His hypothesis is that the disturbance of inhibition in OCD is due to an abnormality of the CSTC circuitry.

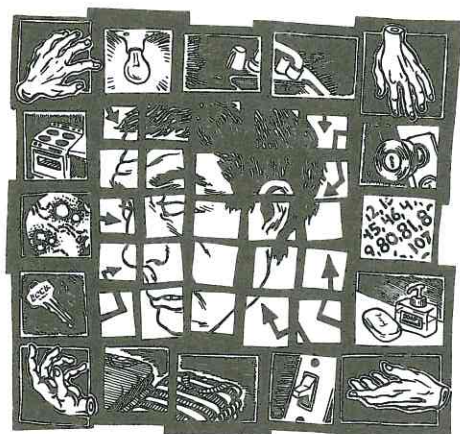
The OCF is giving Dr. Roth \$25,000 to carry out this research. According to Dr. Roth, this project "will provide useful new information on the biological basis of impoverished response inhibition in OCD, and has potential implications for treatment by increasing knowledge of brain circuitry that may be preferentially targeted for treatment."

The Foundation has already begun raising funds to underwrite the grants to be given for proposals submitted in the year 2000. According to President Emmerman, "There is so much work to do to find effective treatments for everyone with OCD that we can't stop fundraising and promoting research." *

**Since being awarded the grant, Dr. Freeston has announced he will be carrying on his work in Great Britain.*

**Research –
Our Lifeline
To A Cure –
Support It**

SPEAKING FOR MY GENERATION



Artwork by: Nolen Strals

Editor's note:

Eric Weiss, editor and writer of Rumpshaker, is going to be writing a column for the OCD NEWSLETTER about the unique experience Generation Xers are having with OCD. We invite your letters and comments in response to his column.

Since this is my first column for this newsletter, I guess some introductions are in order. I'll start. My name is Eric Weiss, and I'm 26 years old. I was diagnosed with OCD in 1992 at the age of 18, though in retrospect I've probably had it since I was about 12 years old or so.

In my spare time, I publish and write an independent fanzine which focuses on punk rock music and culture. This publication, while focusing on music, also acts as a reflection of me—who I am and what I'm all about, including my struggles with OCD.

I realized a long time ago that having OCD, or any mental illness or disorder, is not something to be ashamed of. If I had cancer would I be embarrassed to talk about it? Would I feel weird about writing about it in my fanzine? Not at all.

So why should I be quiet about my OCD, why should I try to hide it? So, in an effort to create more awareness about OCD I have chosen to use my fanzine to not only write about the clinical aspects of OCD, but also to divulge my own personal battles with it. In a small way I am trying to take OCD out of the shadows and into the realm of public discourse, because even within the world of punk rock, where participants pride themselves on the breaking down of cultural and societal taboos, public discourse on mental illness, including OCD, is very rare.

Which is unfortunate. Because I remember what it was like to feel like I was losing my mind, and the pain of feeling like I was losing control. It was scary, it was frightening, it was hell. Upon being diagnosed with, and learning about OCD, my world completely opened up - no longer was I "going crazy" but rather, I knew I had a treatable disorder that I could work on.

It is my hope that through my writing in "alternative" forms of media, such as my fanzine (which has a predominantly youthful readership), and through more mainstream publications, such as this, that I can be a part of the growing numbers of people who are standing up, and speaking out unashamedly about OCD - for themselves, and for those who feel they are "losing it" but don't know where to turn.

*If you would like a reprint of the article on OCD from Eric's fanzine, Rumpshaker, send a self addressed stamped envelope to him at: 72-38 65 Place, Glendale, NY 11385. Or, email him at Rshaker5@aol.com. **

IF YOUR CHILD HAS OCD, YOU SHOULD KNOW ABOUT IDEA

According to the Department of Justice, Civil Rights Division, the Individuals with Disabilities Education Act (IDEA) (formerly called the Education for all Handicapped Children Act) requires public schools to make available to all eligible children with disabilities a free appropriate public education in the least restrictive environment appropriate to their individual needs.

IDEA requires public school systems to develop appropriate Individualized Education Programs (IEPs) for each child. The specific special education and related services outlined in each IEP reflect the individualized needs of each student.

IDEA also mandates that particular procedures be followed in the development of the IEP. Each student's IEP must be developed by a team of knowledgeable persons and must be at least reviewed annually. The team includes the child's teacher; the parents, subject to certain limited exceptions; the child, if determined appropriate; an agency representative who is qualified to provide or supervise the provision of special education; and other individuals at the parents' or agency's discretion.

If parents disagree with the proposed IEP, they can request a due process hearing and a review from the State educational agency if applicable in that state. They also can appeal the State agency's decision to State or Federal court.

For more information about your child's right to an appropriate education, contact:

*Office of Special Education Programs
U.S. Dept. of Education
330 C Street, S.W. (Room 3086)
Washington, D.C. 20202*

*Or
www.ed.gov/offices/OSERS/OSEP/index.html **

A SPIRITUAL LIFELINE FOR THOSE WITH MENTAL ILLNESS

by: Chris Vertullo, member, OCF Board of Directors

Do you know that the Roman Catholic Church has a patron saint for mental illness? Her name is Dymphna and her feast day is May 15th. She was the Christian daughter of a 7th century Irish pagan king and his Christian wife who was murdered by her father when she refused to enter into an incestuous marriage with him.

Dymphna was fourteen when her mother died. Her father, Damon, suffered with mental illness brought on by his grief. He sent his messengers throughout his land to find some woman who resembled his wife and who would be willing to marry him. Unable to please the king, his evil counselors advised him to marry his own daughter. Although incestuous marriages were not unusual in pagan nations, Dymphna fled her castle in disgust with her confessor, Fr. Gerebern, and two chaperones. Crazy Damon found them in Gheel, Belgium. He gave orders to behead the priest. When Dymphna refused to marry him and return to Ireland, he drew his sword and beheaded her. She was only fifteen at that time. It is estimated that Dymphna's martyrdom was somewhere between the years 620 and 640.

The site in Belgium where Dymphna died is known for its miraculous healings. A chapel dedicated to St. Dymphna is part of the present Gheel Colony, a hospital devoted to caring for those suffering with mental illness. Gheel is an unusual town because many residents open up their homes to the mentally ill and treat them as members of the family. The attitude and spirit of this unique healing hospital and town is a doctor's dream. Moreover, the spirit and memory of St. Dymphna lives on, not only in Belgium, but throughout the world, as she continues to intercede to help the mentally and emotionally ill, as well as their loved ones.

For more information about St. Dymphna visit the web or write Franciscan Mission Associates, P.O. Box 598, Mount Vernon, NY 10551-0598. *

STRONGER THAN DIRT – OCD AND CONTAMINATION

by: Fred Penzel Ph.D.

Recently, while going through some back issues of the OCD NEWSLETTER it struck me that unless I was mistaken, there had never really been any special articles written about contamination. Perhaps it's because it is so well known. On the surface, it's not a very complicated subject, dirt, germs, washing-what could be simpler? Actually, when examined more closely, contamination is quite a bit more complicated than that. In addition to being complex, contamination fears can be an extremely serious problem, and can totally debilitate those who suffer from them.

First of all, what we are really talking about breaks down into two parts: contamination obsessions and decontamination compulsions. Let us first examine the nature of obsessive contamination fears. Contamination isn't simply limited to dirt, germs, and viruses. It can also include: bodily excretions (urine, feces), bodily secretions (sweat, saliva, mucus, tears, etc.), blood, semen, garbage, household chemicals, radioactive material, broken glass, greasy or sticky substances, people who appear unwell, shabby or unclean, spoiled food, soap (really!), lead, asbestos, pets, birds, dead animals, and newsprint.

This list is by no means complete. There are practically no limits to the things that could be contaminating. From my own experience, I would guess that the fear of certain illnesses is still the leader. Many years ago, cancer was one of the more commonly feared illnesses. In the last decade or so, this seems to have been replaced by AIDS (see my previous OCD NEWSLETTER article, "OCD and AIDS, When Epidemics Collide").

Obviously, logic has little to do with these fears.

One particularly unusual aspect of contaminating substances is the extent to which tiny amounts of them are often believed to cover very large areas. Some sufferers believe that a minute quantity of a contaminant (such as blood or urine, for example), can somehow be spread to coat entire rooms, or even everything they own.

There is also a whole category of fears of contamination of a stranger and a more magical type of contamination, which could include: thoughts, words, names (of illnesses, disabilities, people who are ill or disabled, or who have died), places where bad things have happened, mental images, overweight or unattractive people, colors, and bad luck.

Obviously, logic has little to do with these fears. The belief here is that these names, images, concepts, or the characteristics of certain people can be magically transferred

simply by thinking about them or by coming into contact with them. They can be every bit as disabling as the items on the previous list.

There is a further category that includes things that are a bit more vague. For instance, there are some sufferers who fear to touch the floor, the ground outdoors, or any public objects. When questioned about what it is they fear they can only reply "I don't really know, it just feels dirty to me." There are also cases where a sufferer will get the idea that another person is contaminated in some way, although they cannot exactly say why. It may be a total stranger, or a member of their immediate family.

Compulsions are the obvious responses of sufferers to these fears. They may involve any protective act that an individual carries out to avoid becoming contaminated or to remove contamination that has somehow already occurred. Compulsions of this type may include: excessive and sometimes ritualized hand washing, disinfecting or sterilizing things, throwing things away, frequent clothes changes, creating clean areas off-limits to others, and simple avoidance of going to certain places or touching things.

When questioned about what it is they fear they can only reply "I don't really know, it just feels dirty to me."

Another form of compulsion can include double-checking by a sufferer to make sure that they have not become contaminated, or asking others for reassurance that this has not occurred. Sufferers will also, at times, repeatedly ask others to check parts of themselves they cannot reach or see, or things they cannot go near. Some will go as far as to make lists of things they believe may have happened in the past, so they won't forget this vital information.

In an attempt to keep clean and minimize compulsions, some sufferers will create two different worlds for themselves, one clean, and one dirty. When contaminated, they can move freely about their dirty world and touch and do anything, since everything in it is already contaminated. Nothing in it has to be cleaned or avoided. Clothes that are considered contaminated must be worn when functioning in this zone. This dirty world usually takes in most of the outside world, and can also include portions of their home or work areas. It may even extend to having a dirty car, to be driven only when contaminated. They may also be able to function freely in their clean world, as long as they themselves are clean when they enter it, and also stay that way. The clean world is usually a much more restricted area than the dirty one,

and is often limited to special places at home or at work. There may also be a clean car, which can only be driven when clean. The two worlds may exist side-by-side like parallel universes that are never allowed to meet.

For magical types of contamination the solution is often a magical decontamination ritual, designed to remove or cancel out the problem thought, name, image, or concept. Saying special words or prayers, thinking opposing or good thoughts to cancel out bad thoughts, and doing actions in reverse are just some of the compulsions that can be seen. Sometimes, the usual washing or showering may even be part of the magical ritual.

Compulsive showering and washing are really quite futile, as the relief from anxiety only lasts until the washer contacts something else that is seen as contaminated.

"Washers," as they are referred to, are probably the most visible among those with contamination obsessions. It is not unusual for them to wash their hands fifty or more times per day. In more extreme cases, hands may be washed up to 200 times per day. Showers can take an hour or longer, and in severe situations can last as long as eight hours.

Obviously, washers go through large amounts of soap and paper towels (used in preference to cloth towels, which can only be used once and create laundry). Their hands often become bright red and chapped with cracked and bleeding skin. Antibacterial soaps, peroxide, and disinfectants such as Lysol(can be used to excess by some, causing further skin damage. I have even worked with several people who poured straight bleach on their hands and bodies, resulting in chemical burns.

Compulsive showering and washing are really quite futile, as the relief from anxiety only lasts until the washer contacts something else that is seen as contaminated. Washing may, in some cases, be very ritualized. It may have to be done according to exact rules, which, if not followed, force the sufferer to start all over again. Counting may also be part of a washing ritual to ensure that it has been done for a long enough period of time, or a certain number of repetitions. In order to cut down on washing, sufferers sometimes resort to using paper towels, plastic bags, or disposable gloves to touch things.

In some cases, family members have been drawn into the sufferer's web of compulsions. They are made to reassure, to clean things

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STRONGER THAN DIRT

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that cannot be approached, to check the sufferer or the environment for cleanliness, or to touch or manipulate things that are supposed to be contaminated. This type of help, of course, doesn't really help, as it only locks the sufferer into the illness and increases helplessness. It also leads to resentment and fighting, as family members feel increasingly imposed upon, and their lives become limited. This is especially true when a family member is seen as the source of contamination.

To further complicate our contamination picture, there is a variant that veers off into what is known as "hyperresponsibility." This is where instead of being fearful of becoming contaminated, sufferers fear spreading contamination to others.

Gradually, patients learn to merge their clean and dirty worlds as they cease to protect themselves.

The types of contamination that can be spread to others are about the same as those that trouble other sufferers. Generally speaking, so are the types of avoidance and decontamination compulsions. There is not only a fear of possibly harming others, but also a fear of having to live with the resulting guilt. There are also some that suffer from both types of fears of simultaneously.

Having briefly covered this very complex topic, the next question would be, what can be done about problems such as these? To those of you familiar with OCD, the answer should be obvious, behavioral therapy and possibly medication. Behavioral therapy would be in the form of Exposure and Response Prevention. This remains the most widely used and accepted form of behavioral treatment for OCD. This type of therapy encourages patients to gradually encounter increasing doses of that which is contaminated, while resisting washing, checking, avoiding or conducting magical rituals. By staying with the anxiety, sufferers come to learn the truth of the matter, that nothing really happens when they face their fears, and that their efforts at taking precautions therefore serve no purpose. Gradually, patients learn to merge their clean and dirty worlds as they cease to protect themselves. They also concentrate on learning to accept that there will always be a certain amount of risk in life that can never be eliminated, and that life can still be enjoyed and lived freely in spite of this fact. By trying to eliminate risk, they come to see that along with it, they will eliminate their ability to function. I like to tell my patients that "When everything is contaminated, nothing is contaminated."

Therapeutic encounters are like small experiments to test patients' theories about the dangers of their particular type of contamination. Treatment is tailored to each particular person's symptoms, and is conducted at his/her own pace. If a feared substance or situation is too difficult to confront in one whole step, it is approached more gradually. Some patients can only touch something that has touched a feared substance or object, and only later do they go on to touch directly what is feared. Family and friends are taught to not participate in rituals and to not give reassurance or answers to repetitive questions. No one is ever forced to do anything, nor is anything sprung upon them by surprise. It takes persistence and hard work but through steady week-by-week work, the disorder is chipped away, until recovery is eventually reached.

Because OCD is biochemical in origin, medication can often be of great assistance as well. I believe it should be regarded as a tool to assist in doing behavioral therapy. Both treatments together are often more effective than either one alone. The main family of medications used to treat OCD is known as SSRIs (Serotonin Specific Reuptake Inhibitors). Basically, they enhance the activity of serotonin, the brain chemical implicated in this disorder. Members of this drug family include Prozac, Celexa, Paxil, Luvox, and Zoloft.

To further complicate our contamination picture, there is a variant that veers off into what is known as "hyperresponsibility." This is where instead of being fearful of becoming contaminated, sufferers fear spreading contamination to others.

If you suffer from this, or any other type of OC disorder, my suggestion is that you seek help. OCD is chronic, and without proper help either stays the same, or gets worse. This means that there is no cure. There is recovery, though, and many have achieved it. With the right treatment, you can hope to live a normal productive life, and go on to fully realize your potential as a human being.

*Fred Penzel, Ph.D. is a licensed psychologist who has been involved in the treatment of OCD for eighteen years. He is the executive director of Western Suffolk Psychological Services in Huntington, New York, and is a frequent contributor to the OCD NEWSLETTER. He sits on the scientific advisory boards of both the Obsessive-Compulsive Foundation and the Trichotillomania Learning Center, and can be reached at (631) 351-1729 or at penzel@attglobal.net. **

A SOLUTION FOR THE HARDEST THING

"The hardest thing after you finally get a diagnosis for your child or your spouse or yourself," says Carter Waddell, member of the OCF Board of Directors, "is to find a competent treater that you can work with. There just aren't enough OCD specialists to go around yet."

"It's a shame, but this is one of the problems that the Foundation was created to deal with, but it's still here," says Fran Sydney, one of the founding members of the OCF board of directors.

"With this as an impetus, the board of directors has surfaced an idea that they hope catches on," Waddell told the NEWSLETTER. "It's something I did myself when looking for a treater for a family member. After much searching, I found a psychiatrist that we liked and that was good, but not an OCD specialist. So, I bought her a professional membership in the Foundation," explained Waddell.

"It's a perfect solution," stated Janet Emmerman, president of the board of directors when Waddell introduced this idea to the Board.

OCF Membership Is A Lifeline

"We should encourage our members to do it. It will increase the number of treaters available and that's what we need. They will get the NEWSLETTER with current practice articles, learn about the Annual Conference which has more seminars on more OCD and Spectrum Disorders than any other conference taking place now. They will have access to all the best books and tapes on the treatment of OCD and can attend a Behavior Therapy Institute at membership rates. The Foundation is behind this idea completely."

"For those interested, all you need to do is send in a membership application from the back of the NEWSLETTER or off the Website or call the Foundation," said Hannah Carlson, OCF's membership director. "You can do it for groups and schools, and other institutions, too. Sign up anyone or group you'd like to be more informed about OCD and it's treatment." *



TECHNIQUES FOR ADDRESSING OCD TREATMENT RESISTANCE IN CHILDREN: THE STAGE OF CARE WE ALMOST FORGOT

by: Julie Powell Ward, Ph.D., partner Tulsa Developmental Pediatrics &
Center for Family Psychology

When I saw Teddy Fisher sitting in the waiting room before his appointment, he was about the most solemn 10 year old I had ever seen. Twelve year old Ashley Freeman had a similar facial expression the first time I saw her waiting for an appointment. In fact, my waiting room has been a parade of very serious, intense looking children for many years. Who are these children? Any therapist who has treated childhood OCD will recognize them at once. They are kids whose fears and worries have consumed them. They are waiting to have their worst nightmares confirmed by a specialist. They are biding their time until someone in authority tells them that they are crazy.

Treating childhood OCD is recognized by many professionals as a rather tricky business. Not only do children often lack insight into the nature of their difficulties. They also present a wall of resistance that they have perfected over their short lives. This resistance keeps everyone around them from knowing how sick and weird they believe they are and they hold onto it with a vengeance. These are children who have been disciplined for actions that they can't help and told to "snap out of it" by people whose opinion they trust. It is little wonder that children come into the treatment setting with about the same openness to help as you might expect from court ordered prison inmates.

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To complicate the picture of treating OCD children just a little further, it is thought that OCD is misunderstood by parents and misdiagnosed by many treating professionals. Consequently, many children suffer the symptoms in misery for quite some time and reach a point of desperation and parental exasperation before arriving at the therapist's office. These types of circumstances set a foundation of rigid barriers to treatment that should be well understood by specialists who treat OCD in children. The most comprehensive array of treatment techniques are rendered useless as these children stubbornly protect the appearance of sanity. Therapists can easily become frustrated as their efforts to treat these children fall flat. Treatment failures and aborted attempts at getting help further reinforce to these worried children that no one can understand or help them. What is it that differentiates a therapist who can successfully reach a child who is this well-

defended from one who cannot? My experience and training in working with many of these children has given me a clue to unlocking this mystery. Simply put, you cannot treat anyone who is not a candidate for treatment. In other words, the therapist must first help create a candidate for treatment within the child without which other efforts will likely fail to be of benefit. When therapists miss this pivotal point, they fail to hear the child's most prominent message. They miss the opportunity to ease the life-threatening fears that shelter all the symptoms. They essentially begin treatment in the middle instead of at the beginning, reducing the likelihood of treatment successes. They covertly communicate to the child that all that protective armor is really necessary.

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Most specialists in treating children's psychological difficulties readily observe the prominence of treatment resistance and recognize the importance of overcoming it as a prerequisite to helping the child. When children with OCD are highly anxious, this resistance frequently presents as particularly intense and rigid. The ability of the therapist to understand and confidently address these barriers is critical in working with OCD children. This requires a solid knowledge base in this disorder and a set of techniques that begin where the child is stuck.

Research is strongly suggesting that OCD in children is best treated with a set of cognitive behavioral tools, often in combination with medication. The education of parents and the family is also considered an essential part of the overall treatment package. The actual treatment of these children is not highly complicated as long as the therapist is well trained in a wide variety of techniques. The developmental considerations in working with children, however, require a unique connection between the child and the therapist before an incentive to engage in the treatment process can be developed. The typical low motivation of children to make changes must be countered by highly engaging, enjoyable and frequently novel interactions that capture the child's interest. Play therapy has long been regarded as an approach of choice in

this regard because children naturally gravitate toward and feel comfortable in play situations. However, there is little evidence that play therapy alone is an effective treatment tool. So how does one engage these defensive, solemn children who are sitting nervously in your waiting room? A therapist who is insightful enough to know that this is a pivotal question is in the right place to look for the answer.

Studies of child development show us that healthy children want to have fun, play, engage in silliness, joke around and enjoy the company of children and adults who enjoy doing these things with them. The OCD child has often compromised these essential actions to guard against others' discovering their secret thoughts and beliefs.

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Frequently appearing like small adults, these children will be the ones in your waiting area who are reading their history book while other kids are playing noisily. The loss of this critical piece of childhood is a key to the therapist's chances at connecting with the child. If therapists are able to show these distressed children some ways to have fun, they have begun to normalize the child's experience. Therapists who are able to use humorous, lighthearted techniques while getting acquainted with these children have taken the first steps toward allaying the child's fears of craziness.

One child I saw told his mother that he was very worried that he was crazy and was sure that if I worked with him that I would go crazy, too. How did I reassure this child? I told him that it was impossible to make me crazy because I was already crazy. This comment illustrates the idea that the therapist doesn't find anything frightening in the child's condition. In fact, the condition is so non-threatening that the therapist refuses to worry along with the child. This modeling and covert message of acceptance and comfort in the face of the intense symptoms of OCD is an important marker for perceptual change. The child must be assisted in changing his/her perception of his symptoms as a precursor to talking about them openly.

The experienced child therapist has usually accumulated a wide variety of activities, playthings, and attention-getters for working with children. The presentation of the therapist's office as a fun, lighthearted and silly place is another means of communicating the message of normalcy to the child. Since therapists can't effectively talk OCD children out of their worries, they must be prepared to demonstrate

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TECHNIQUES FOR ADDRESSING TREATMENT RESISTANT CHILDREN

Continued from page 6

a playful and fearless attitude. This requires a great deal of energy and creativity as well as a good sense of humor on the part of the therapist. Therapists who have worked extensively with children have usually had to mobilize these resources and energies and recognize the necessity of doing so.

The initial meetings with a very worried and defensive OCD child should be directed toward establishing a foundation of acceptance, understanding and mutually enjoyable interaction. I have developed techniques and materials for laying this foundation with children that work well for me. However, the point in describing them is not to suggest that this is the definitive way to treat this OCD defensiveness. Rather, the descriptions I provide are meant to illustrate some examples of the types of methods that seem to help allay children's hidden fears.

When I walk the child into my office for the first time, I often contemplate what the child must be expecting. These serious-minded children are usually picturing the worst possible scenarios of treatment from ideas they've acquired about going to shrink's offices. Importantly, the child's first impression of the real setting for treatment should debunk this expectation instantly. A very worried child should see the therapist's office as a place of surprising friendliness. The child's experience of this therapeutic environment should instantly set in motion the therapist's goals for alleviating the child's pain.

*When I walk the child into
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My office is painted in bright primary colors. The walls are adorned with children's drawings and paintings. Things of interest dangle from the ceiling and a ladder leads up shelves full of interesting toys. A live parrot greets newcomers with squawks and whistles from its perch on a large rocking chair. Cages house a large green iguana, another bird and an unusual-looking rodent. A large clock sits in the center of the table with a glass center full of candy. A signed picture of Jack Nicholson and his dog from the latest movie depiction of OCD hangs prominently behind the parrot. The message communicated by this room is so loud that it is all a child can do to keep from laughing. And that is exactly the place I want to start.

My first therapeutic act is to show the child around my office while telling crazy stories about some of the things that my pets have done. I talk kid-talk. I crack jokes. We share stories about our pets. We check out the toys and toss them around a little. I will usually make some stupid blunder and laugh at myself. I may do something unexpected like coax a bird onto my head. I just generally use my imagination along with everything I know about what children enjoy. I welcome OCD children into a way of viewing themselves that never occurred to them before. I goof around and have fun until they experience a glimmer of hope. And I don't pull out any treatment techniques until children invite me in. This doesn't take very long under the circumstances.

The treatment of childhood OCD requires a heightened sensitivity to the child's loss of usual childhood pleasures. These losses, though sometimes not recognized by the child, reflect the trauma of this condition in the child's experience. Modeling childhood's frivolity as a therapeutic act places the therapist squarely in the world that the child wants so badly to enter. The therapist's ability to successfully demonstrate a playful and relaxed attitude should be viewed as an essential skill in working with these children. The therapist must be prepared to present help to the child in a way that relieves intense worries without saying a word. The therapist must show the child how to laugh in the face of adversity. The child learns to share long-buried ideas as though they lacked the power to scare people off. By the end of the session, the child wants to know when the next session will be.

The conditions for treating OCD children described here should be viewed as Stage 1 of the overall plan of care for the child. The place where many traditional therapies begin including the initial interview and presentation of techniques becomes, more accurately, Stage 2. This concept of the treatment process reflects the importance of the accumulated research on children's patterns of resisting treatment. It conventionally places the rapport before the care but in a way that immerses the child in the message without the therapist engaging in the power battle. And, most importantly, it reflects a simple concept that I use as part of my cognitive behavioral treatment with children. I show them a picture of a ladder and ask them if they wanted to climb it which step would they take first. I praise them when they say step 1 and tell them they may need some ladder-climbing lessons if they say anything else. *



BOOK REVIEW

Treatment of Obsessive-Compulsive Disorder, by Lata K. McGinn, Ph.D. & William C. Sanderson, Ph.D. Published by: Jason Aronson, Inc., 1999, Northvale, NJ.

Review by Lee Baer, Ph.D., Associate Professor of Psychology, Dept. of Psychiatry, Harvard Medical School and Massachusetts General Hospital

One of the most promising developments in non-drug treatment for OCD over the past decade has been the finding that, for many patients, cognitive therapy techniques - similar to those used by Dr. Aaron Beck for treating depression, but modified to address the particular cognitive distortions common in OCD - are equally effective for exposure and response prevention treatments.

Dr. Lata McGinn of Albert Einstein College of Medicine/Montefiore Medical Center in New York and Dr. William Sanderson of Rutgers University in New Jersey are clinical psychologists with extensive experience in using behavior therapy techniques and cognitive therapy techniques for various anxiety and depressive disorders. Their book is intended as a treatment manual to teach practitioners how to integrate the newer cognitive restructuring approaches for OCD with the older and better-established exposure and response prevention treatments for this disorder. The authors have succeeded admirably in achieving their goal.

Clinicians with no experience treating OCD, or those seeking information about integrating cognitive therapy for this disorder, will find the step-by-step instructions, along with the simulated therapy session transcripts provide a clear introduction to this method.

Some shortcomings of the book are the lack of discussion of standard rating scales clinicians should use to assess OCD severity and progress, such as the Yale-Brown Obsessive Compulsive Scale (YBOCS), and focusing only on the use of cognitive techniques and exposure techniques for classic OCD symptoms such as contamination and harming fears, without discussing complicated OCD-related problems often seen in clinical practice including body dysmorphic disorder, complex tics, and fixed beliefs interfering with treatment, including fixed religious beliefs. The lack of discussion of these issues means that this book should be used by the clinician as a supplement to other more comprehensive treatments of OCD-spectrum disorders rather than standing alone as a comprehensive guide to treating these disorders.

Although this book is not intended as a self-help guide for patients, the OCD sufferer interested in learning more about this treatment approach might find it helpful, despite the technical jargon that is unavoidable in any book intended for professionals. *

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.

Compulsivity and obsessionality in opioid addiction

Journal of Nervous and Mental Disease, 188:155-162, 2000, I. Friedman, R. Dar and E. Shilony

Seventy-one individuals with opioid dependence participated in a personal interview assessing the importance of their opioid-use rituals. Findings suggest that many opioid-dependent individuals take their drugs in a ritualistic manner and that the need for a fixed ritual is a major component in opioid dependence. The level of compulsivity and obsessionality in opioid dependence was comparable to that found in OCD and alcohol addiction. In addition, 11.4% of those with opioid addiction also met the criteria for an OCD diagnosis, a rate which is over 4 times higher than the rate of OCD in the general population.

A family study of obsessive-compulsive disorder

Archives of General Psychiatry, 57:358-363, 2000, G. Nestadt, J. Samuels, M. Riddle et al.

The role of heredity in OCD has long been suspected. This study reports three main findings. First, OCD is familial, meaning OCD occurs in more members of a family than would be expected by chance. The first-degree relatives (e.g., parents, siblings) of patients diagnosed with OCD had a nearly 5-fold higher lifetime prevalence of OCD. Second, obsessions are more specific to the familial aspect of the disorder than are compulsions. Relatives of patients are at greater risk for both obsessions and compulsions than the relatives of individuals without OCD; however, the magnitude of the association is substantially stronger for obsessions than compulsions. Third, earlier age at onset of the symptoms of OCD indicates a more familial subgroup.

Fearful consequences, fixity of belief, and treatment outcome in patients with obsessive-compulsive disorder

Behavior Therapy, 30:717-724, 1999, E.B. Foa, J.S. Abramowitz, M.E. Franklin et al.

This study examined the degree to which the presence of feared consequences and poor insight into obsessive-compulsive symptoms

influenced the benefit of behavior therapy for OCD. Twenty OCD patients received behavior therapy, exposure and ritual prevention, and the patients' degree of insight into the senselessness of their obsessional beliefs was measured. Patients who were extremely certain that their feared consequences would occur had poorer outcome than patients with mild or moderate certainty. Extremely poor insight may indicate the need for additional treatment options such as treatment with medication in addition to behavior therapy.

Multicentre, double-blind comparison of fluvoxamine and clomipramine in the treatment of obsessive-compulsive disorder

International Clinical Psychopharmacology, 15:69-76, 2000, E. Mundo, G. Maina and C. Uslenghi

Study results show that fluvoxamine (Luvox) and clomipramine (Anafranil) have similar effectiveness in the treatment of OCD; 60% response in the fluvoxamine group and 67% response in the clomipramine group. There were more patient dropouts due to side effects in the clomipramine group and there were significantly more reports of constipation and dry mouth with clomipramine. With fewer side effects, fluvoxamine was better tolerated, providing an advantage in long term treatment which is usually needed in OCD.

Naturalistic course of obsessive-compulsive disorder and comorbid depression

Psychopathology, 33:75-80, 2000, W. Zitterl, U. Demal, M. Aigner et al.

Seventy-four patients with obsessive compulsive disorder (OCD) were studied in a prospective follow-up study in order to investigate the course and prognosis of OCD with or without comorbid depression. The study found that if OCD symptoms decreased, depressive symptoms also decreased. In most cases OCD is dominant over depression, and this suggests a priority for the treatment of OCD over the treatment of depression. Fortunately, the potent serotonin reuptake inhibitors (clomipramine and the SSRIs) necessary for treatment of OCD are also effective antidepressants.

People who hoard animals

Psychiatric Times, 17(4):25-29, 2000, The Hoarding of Animals Research Consortium and R. Frost

Research on animal hoarding is in its infancy, despite its seriousness and the frequency with which it is described in the news media. This article reviews existing literature on the hoarding of animals. Nearly two-thirds of animal hoarders are women, 70% are unmarried, and social isolation is common but appears to result from the hoarding behavior rather than causing it. As people who hoard pos-

sessions, animal hoarders often lack insight into the problematic nature of their behavior. A common and peculiar characteristic of animal hoarding is a persistent and powerful belief that they are providing proper care for their animals, despite clear evidence to the contrary. Careful assessment is needed to determine if these beliefs reflect a delusional disorder or overvalued ideation in the context of OCD.

Rate of body dysmorphic disorder in dermatology patients

Journal of the American Academy of Dermatology, 42:436-444, 2000, K.A. Phillips, R.G. Dufresne Jr., C.S. Wilkel et al.

Dermatologists appear to be the physicians most often seen by patients with the psychiatric condition, body dysmorphic disorder (BDD), a distressing or impairing preoccupation with a nonexistent or slight defect in appearance. Using a self-report questionnaire, this study found that 11.9% of 268 patients seeking dermatologic treatment screened positive for BDD. In addition, a sizable percentage of these individuals with BDD reported experiencing severe or extreme distress or functional impairment, which in some cases consisted of missing work, staying in the house, and avoiding family and friends.

Sensory phenomena in obsessive-compulsive disorder and Tourette's disorder

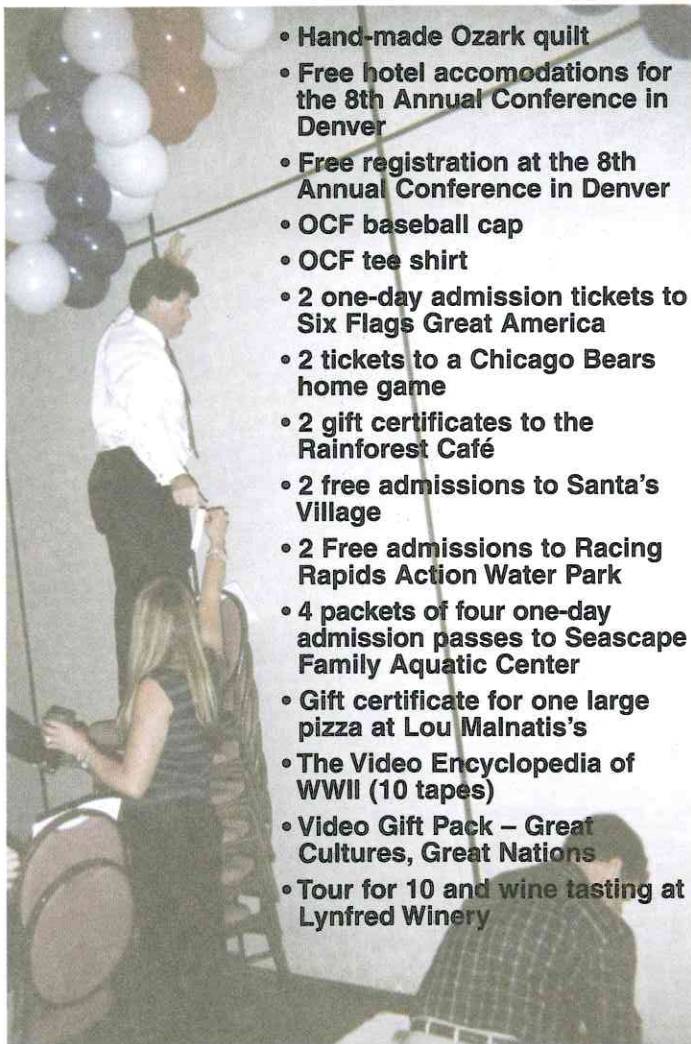
Journal of Clinical Psychiatry, 61:150-156, 2000, E.C. Miguel, M.C. Rosario-Campos, H. Silva Prado et al.

Sensory phenomena in patients with OCD and/or Tourette's disorder were investigated to determine if these phenomena are valid clinical features for differentiating tic-related OCD from non-tic-related OCD. Bodily sensations include localized or generalized body sensations occurring either before or during performance of the repetitive behaviors. These sensations are more frequently found in patients with OCD plus Tourette's disorder than in patients with OCD alone. Mental sensations include urge only, tension, incompleteness, and just-right perceptions. These are also more frequently found in patients with OCD plus Tourette's disorder than in patients with OCD alone. The researchers conclude that sensory phenomena may be an important feature for grouping patients along the OCD-Tourette's disorder spectrum.



Raisin' Money with a Raffle for Research

A new feature at the 7th Annual Conference is the Multi-Item Raffle for Research. OCF staff and volunteers have been calling and writing to local Chicago restaurants and entertainment spots, soliciting gift certificates, coupons and merchandise for the Research Raffle. To date, the following are items that have been contributed and will be raffled off Saturday, August 12. You can take your chance on one item or all the items. Tickets will be sold at the Conference – \$5.00 a yard.



Your Research Dollars at Work

Nathan A. Shapira, MD, PhD, is the lead investigator for a University of Florida study testing a medication, tramadol hydrochloride, as a treatment for Obsessive Compulsive Disorder that did not respond to more conventional treatments. Dr. Shapira received an Obsessive Compulsive Foundation Research Award for this on-going study in 1999. Dr. Shapira is also receiving funding for this study from the National Alliance for Research on Schizophrenia and Depression.

What is different about this research sponsored by the OCF is that tramadol is usually prescribed as a painkiller. However, in 1998, Dr. Shapira learned from a colleague that a refractory OCD sufferer had experienced hours of relief from her OCD symptoms after being administered Tramadol as a painkiller for childbirth related surgery.

In October of 1999, Dr. Shapira and his group started signing up volunteers with treatment-resistant OCD for a double blind study of the effects of tramadol. This study is free and all participants will be able to receive tramadol upon completion of the study.

In a phone interview, Dr. Shapira stated that the study is still ongoing and that individuals with treatment-resistant OCD are urged to contact him at the University of Florida Department of Psychiatry, using the special study number 1-877-788-3994.

**– Research Raffle –
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