OCF Obsessive Compulsive Foundation

OCD Newsletter

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DR. JENIKE URGES EVERYONE IN THE OCD COMMUNITY TO CONTRIBUTE TO THE OCF RESEARCH FUND

Dear Friends,


Dr. Michael Jenike

In 2006, the Obsessive Compulsive Foundation began funding seven very high quality grants for a total of $331,081. The details of the individual studies have been outlined in previous newsletters. We want to cure OCD, and these researchers are helping towards this most ambitious goal.

This has in many ways been a remarkable year for OCD research with powerful findings in the areas of OCD genetics and biology. In addition, people have been exceedingly generous this past year with many millions of dollars being raised privately for OCD research. The remarkable 10 million-dollar commitment to Massachusetts General Hospital from a family in Houston has inspired us all.

The OC Foundation and all those it represents need your support once again to raise money for OCD research. Through the OCF Research Fund, the Foundation supports research into the causes and treatment of OCD. The OCF has been able to raise money to support many of its programs (the OCD Newsletter, web site, Annual Conference, Behavior Therapy Institutes, just to name a few) from various sources. But it depends entirely on you – people with OCD, family members, treatment providers and friends – to be able to fund its Research Awards Program.

There has recently been a great deal of publicity about OCD and related disorders which has greatly heightened awareness of these conditions; but only the sufferers, their families and those who treat them can understand the cruel and disabling pain and suffering that they cause. Every day I talk with patients and their family members who are suffering unrelenting, unspeakable anguish. I still don't know of any other disorder where the sufferer experiences such excruciating mental pain.

The World Health Organization ranks OCD as one of the ten most disabling conditions worldwide, and we know that it has a prevalence of between 2% and 3% of the world's population. With such a burden of suffering as well as lost productivity to the world's economy, it is striking that so little money is raised for OCD research. Since there is much less federal money available at this point, research funding from the National Institute of Mental Health has fallen considerably and investigators throughout the United States are struggling to keep research programs together.

In 2002, the OC Foundation established the OCF Genetics Collaborative and we need to raise money to fund the research being done by the members of the Collaborative. We have enlisted the world's finest researchers in the field of OCD genetics. If genes can be identified for OCD and related disorders, researchers can eventually figure out what these genes do and perhaps correct the deficit. It would also help to identify the children who may be at high risk for developing OCD.

We need your help to find the causes of OCD and in developing new and more effective treatments. Please give generously to OCF's Research Fund.

Sincerely,

Michael A. Jenike, M.D.
Professor of Psychiatry
Harvard Medical School
Chair, OC Foundation Scientific Advisory Board

WE'RE CONTINUING OUR REQUEST FOR PROPOSALS

JUST A REMINDER: PROPOSALS FOR THE 2007 OCF AWARDS ARE DUE JANUARY 15, 2007

The Obsessive Compulsive Foundation, as announced in the last issue of the OCD Newsletter is seeking Research Proposals for its 2007 OCF Research Awards. The deadline for submissions is January 15, 2007.

Topics of Interest

"While the Foundation is interested in all types of research that are related to OCD, this year's particular Topics of Interest, according to Patricia Perkins, the executive director of the OCF, included studies of the brain, its chemistry, structure and functioning; the genetics of OCD; neurobiology; OCD's economic effects on sufferers, their families and the national economy; the pathophysiology of OCD; cognitive and behavioral aspects of OCD; cognitive-behavioral treatment mechanisms; and all aspects of OCD and the OC spectrum disorders that could lead to prevention and treatment advances.

According to Jeannette Cole, the deputy director of the OCF, this year all submissions must be submitted on-line. The on-line application is located at the Foundation's web site, www.ocfoundation.org. Instructions for how to submit a grant application on-line are also located on the web site. "We changed to an electronic application to make the process easier for both those who are submitting proposals and those that will be reviewing and ranking them," said Ms. Cole. "We decided to modernize our submission process," she explained, "to make it easier for everyone. We think that the judging and ranking will be more efficient if all reviewers have on-line access to the grant proposals." According to Ms. Cole, "it was hoped that by employing on-line submissions, we will be able to make the judging more efficient and less time consuming."

Please remember the deadline for submission by e-mail is midnight, EST, January 15, 2007. If you have any questions about the Topics of Interest, the applications guidelines or how to submit your proposal by e-mail, please contact Ms. Cole at (203) 401-2069 or email her at cole@ocfoundation.org.

SUBMISSION DEADLINE IS JANUARY 15, 2007

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Please Donate to the OCF's Research Awards Program

Bulletin Board

FAMILY RESEARCH: THE HOPE FOR TOMORROW

A team of investigators at the Johns Hopkins University School of Medicine has been studying the occurrence of Obsessive Compulsive Disorder (OCD) in families. OCD may have its onset at a young age and it can be benign or extremely disabling. While many treatments have proven effective, we still need to learn more about this disorder. It is critical to learn about the biological basis of OCD to further improve treatments.

At Johns Hopkins School of Medicine, we are now investigating genetic factors which may increase the susceptibility to OCD. Everyday we are coming closer to understanding the complexities of OCD. We are seeking help from families with OCD to help us conduct these studies. With your help, there is hope for better treatments tomorrow.

How You Can Help!

Families having two or more relatives with OCD are invited to participate in the study. Participants will be given a confidential psychiatric interview and if possible we would like to obtain a small sample of blood. The interview will be conducted at a place and time convenient for you. Confidentiality of all information is assured. Families may be referred by a clinician or may contact us. Each participant's help is vital and it brings us one step closer to getting crucial answers.

To learn more about the study please call Gerald Nestadt, M.D., M.P.H., at (410) 614-4941 and a Research Associate will contact you. Or write: The Johns Hopkins University School of Medicine, Department of Psychiatry, 600 N. Wolfe Street, Meyer 4-181, Baltimore, MD 21287. Email: jacks@welchlink.welch.jhu.edu.

ANNOUNCING THE START OF A G.O.A.L. (GIVING OBSESSIVE COMPULSIVES ANOTHER LIFESTYLE) GROUP

Starting in January of 2007
Running from 6:30 pm to 8:00 pm of the 1st and 3rd Mondays of the month.
Groups will be at One to One Psychological Services, 65 Middles Street, Manchester, NH

Professional Assistant: George A. Torrice, MA, NHLMHC, (603) 622-7959 or (603) 860-3418. The purpose of this group is to help prevent relapse by continuing to have sufferers work on exposure and response prevention therapy in a group setting. For questions on the group, please contact George Torrice at either number above.

TRICHOTILLOMANIA/ SKIN PICKING SUPPORT GROUP

Date: First Tuesday of the Month
Starting on December 5, 2006
Time: 7:00 – 8:00 pm
Location: Lakeside Center for Behavioral Change
14525 Highway 7
Suite 340
Minnetonka, MN 55345
Facilitator: Dr. Renae Reinardy
Contact Info: (952) 367-4100 (Phone)
drreinardy@lakesidecenter.org

General Information: This free group is for people ages 18 and older that are living with trichotillomania or skin picking. The group will be therapist-assisted, but this is not a therapy group. This means that Dr. Reinardy will not prepare an agenda for meetings, but will answer questions and serve as a facilitator. The group will provide an opportunity for individuals with TTM and skin picking to meet one another and share experiences that have been helpful and not so helpful in living with these symptoms. If you would like to participate in the group or have any questions, please contact Dr. Reinardy.

DRUG STUDY FOR HAIR PULLERS

Do you pull your hair? Is it causing problems? Does it feel out of control? We are currently seeking volunteers for a drug study for hair pulling. Participation is confidential and requires visits to our Minneapolis, MN site. Please email or call if you would like more information.

Brian Odlaug, Reseach Coordinator, Department of Psychiatry, University of Minnesota, (612) 627-4363 (confidential line), email: odla0019@umn.edu.
Jon Grant, M.D., Department of Psychiatry, University of Minnesota, (612) 273-9736 (confidential line), email: grant045@umn.edu.

TREATMENT FOR OBSESSIVE COMPULSIVE DISORDER

The Anxiety Disorders Center at Hartford Hospital/Institute of Living is conducting research on new ways to treat obsessive compulsive disorder. The study is open to adults ages 18-65 who have OCD. Participants in the ongoing studies will receive free cognitive-behavioral therapy, one of the most effective treatments for OCD. People who are not currently taking medications for OCD may be eligible for a study on cognitive-behavioral therapy in combination with an experimental medication. People who are currently on medications for OCD may be eligible to participate in a study of CBT using "stepped care" – a model of treatment which begins with less intensive therapy and moves to more intensive therapy for those who have not yet reached maximum benefit.

For more information, please call Sarah Carlson at (860) 545-7707 or visit us on the web: www.instituteofliving.org/ADC/index.htm.

FAMILIES WITH OCD

Families with Obsessive Compulsive Disorder are invited to help scientists learn more about the causes of OCD. Recent advances in molecular biology and statistical genetics make it possible to

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OCD NEWSLETTER

The OCD Newsletter is published six times a year.
Obsessive Compulsive Foundation, Inc.
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Joy Kant, President, Board of Directors
Patricia B. Perkins, J.D., Executive Director/Newsletter Editor
Michael Jenike, M.D., Chairperson, OCF Scientific Advisory Board

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

A Message From the President

Dear Friends,

Where would the Foundation be without the support of you and all the other members?

Many of you have volunteered your time at our Annual Conference, formed Affiliates, led support groups, donated money for research, written letters encouraging the passage of mental health legislation, offered your professional services in the areas of marketing and law, and have been there to listen to those who are struggling. You know that working together will make a difference.

During my three years as President, I have worked alongside two distinct groups, the staff that is based in New Haven, Connecticut, and the members of the Board of Directors. Many of you have had direct contact with our dedicated staff members: Deputy Director, Jeannette Cole; Program Director, Daisy Sanchez; and Membership Coordinator, Mary Grande. Working together with our Executive Director, Patricia Perkins, they are constantly tending to the needs of the OCF members. As the membership has grown, the demands on the staff have increased dramatically. I want to extend a special thank you to Patti, Jeannette, Daisy and Mary for your tireless efforts.

This edition I would also like to acknowledge the OCF board member who preceded me as President.

Jan Emmerman

In 1996, the Affiliates unanimously voted Jan Emmerman onto the OCF Board of Directors as an Affiliate Representative. Jan was on the Board of the Chicago Affiliate and was one of its original founders, bringing her business background and her own personal experiences as a mother of a son with OCD. She received her Bachelor of Science degree from the University of Wisconsin in Medical Microbiology and her Masters in Business and Management from Northwestern University.

Jan eventually became President of the national OCF Board of Directors, a postion that she held for four years. Jan has been a member of the Finance Committee, the Research Awards Committee, and the Affiliates Committee. Her interest in medicine is evidenced by her careers: Research Associate at the University of Illinois Medical Center (where she performed research into various adverse conditions upon test bacteria); Supervisor of Infectious Diseases at Northwestern University Medical Center and Evanston Northwestern Hospitals; Director of Research and Specialty Units at Evanston Northwestern Hospitals; Director of Medical Waste (for medical waste and related hospital regulatory concerns) and Senior Director of Marketing at Waste Management, Inc.

Jan is currently President-elect of the Woman's Board of Evanston Northwestern Healthcare and a member of the Associate Board of Directors for Twin Orchard Country Club. Jan is an avid skier, golfer, and tennis player. She enjoys traveling with her husband, Herb, and her two sons, Andrew and Stuart.

According to Jan, "OCD has been a challenge in our lives, but I believe that while we probably could have happily done without the experience, we have become enriched in many ways. One specific example is my volunteer work with the OC Foundation and knowing that it has been responsible for stimulating research into OCD and increasing awareness of OCD as a neurobiological illness that requires treatment and a lot more funds and energy directed into finding a cure and preventive measures."

As Jan mentioned, with everyone's support, we can change the way mental health is perceived and treated.

If you can, please donate to our annual request for monetary contributions for research as outlined by Dr. Jenike on the front page of this issue. Every year we hope that our investigators will find the answer.

Happy Holidays!

Joy Kant
President of the OCF Board of Directors

Long-Term Outcome Study of OCD at the Yale OCD Clinic

by Michael H. Bloch, M.D., Suzanne Wasylink, R.C.N., Philip A. Dombrowski, B.A., Angeli Landeros-Weisenberger, M.D., Vladimir Coric, M.D.

Great advances in the treatment of OCD have been made over the past two decades. The discovery and use of serotonin reuptake inhibitors (SRIs) has dramatically improved patient outcome. Between 40-60% of OCD patients given an adequate trial of an SRI experience remission of their symptoms. Furthermore, two effective psychotherapy based treatments, cognitive-behavior therapy (CBT) and exposure-response prevention (ERP), have been implemented in the treatment of OCD during the last two decades. CBT with ERP seems to be at least as effective as pharmacological interventions for OCD.

Prior to the introduction of these treatments, OCD was considered a chronic, lifelong condition with a fluctuating, although unremitting course. In a follow-up study conducted by Skoog & Skoog of 144 patients treated for OCD in Sweden, only 20% exhibited complete recovery after 40 years of treatment. Although a substantial proportion (83%) experienced a decline in symptom severity from the point of their initial hospitalization, over half (52%) still had clinically-significant OCD symptoms 40 years later. Other retrospective studies from the same time period, (before SRIs and CBT), estimate that clinical improvement was experienced by 32-74% of OCD patients who were followed-up at time intervals of 5 years or longer. No long-term follow-up studies (duration greater than 5 years) examining the clinical course in OCD patients have been published since the widespread adoption of SRIs and CBT with ERP for the treatment of OCD. Although these earlier studies greatly advanced our knowledge of OCD, prognostic information regarding long-term outcome is not generalizable to current OCD patients who receive more effective treatment.

The Connecticut Mental Health Center and Yale OCD Clinic have been involved in providing treatment to OCD patients for more than two decades. The Yale OCD Clinic was a site in early clinical trials of pharmacological interventions that

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Training Clinicians to Treat OCD: The Behavior Therapy Institute Experience

by Charles Brady, Ph.D.
Department of Psychiatry
University of Cincinnati College of Medicine

Fall leaves, playoff baseball, and the 630 foot Gateway Arch provided a distinct mid-western autumnal backdrop to this year's second OC Foundation Behavior Therapy Institute (BTI). Twenty-four clinicians representing psychology, psychiatry, and clinical social work descended upon the Saint Louis Behavioral Medicine Institute's conference room to participate in the OC Foundation's Fall BTI training weekend. The clinicians arrived from private practice settings, academic medical centers and hospitals from throughout the Midwest, and from points as far east as Connecticut, as far west as Seattle, and as far south as Mexico. Although the level of experience treating OCD sufferers ranged from clinicians who had treated less than five OCD sufferers to those treating 10-12 OCD sufferers per week, participants shared the common goal of advancing their skills in the treatment of OCD and OC spectrum disorders.

Days 1 & 2: Conceptual to Practical – Lectures on the Treatment of OCD

The bevy of participants was greeted cheerfully Friday at 8:00 a.m. by C. Allec Pollard, Ph.D., Director of the Anxiety Disorders Center of the Saint Louis Behavioral Medicine Institute. Dr. Pollard spent the next nine-and-a-half hours helping participants acquire and integrate knowledge of OCD treatment and assessment. Dr. Pollard's vast experience as a frontline clinician treating OCD was evidenced by his ability to present an easily digested conceptual model of the cognitive, behavioral and emotional facets of OCD treatment. He taught participants to develop a treatment approach from an integrated model of how OCD symptoms are developed and maintained. The presentation included a discussion of various cognitive and behavioral interventions and the inter-relatedness of these interventions in the course of treatment. Dr. Pollard concluded his presentation with case illustrations of cognitive and behavioral interventions to specific OCD cases, including contamination obsessions, scrupulosity, harming obsessions with checking compulsions, and "just right" OCD. The format of the presentation was informal with substantial levity. Dr. Pollard encouraged and responded graciously and expertly to an assortment of questions. The material presented and the style of the presentation was well received and appreciated by all, regardless of experience level.

On Saturday, a cup of coffee and a cherry scone from the St. Louis Bread Company and no commuter traffic on I-64 allowed this writer to reach the Saint Louis Behavioral Medicine Institute well before the 8:00 a.m. start. Reed Simpson, M.D., from the psychiatry faculty of Washington University began the day's agenda with a cogent overview of the pharmacologic treatment of OCD, including the efficacy of mono-therapies and the use of augmentation approaches. BTI participants left his presentation with sound familiarity with the array of medical treatment approaches available in the battle against OCD.

Karen Cassiday, Ph.D., of the Anxiety and Agoraphobia Treatment Centers in Northbrook and Chicago, Illinois, followed Dr. Simpson's presentation with a lively interactive presentation on treating OCD in children and adolescents. Participants learned to tailor exposure and response prevention strategies for younger patients. Dr. Cassiday introduced participants to exposure games, reviewed the importance of positive reinforcement, and provided useful tips on working with families who have a child engaging in exposure and response prevention treatment. This presentation gifted the participants with many useful concepts and practical applications, not limited to "the nag book" and the "jelly bean stomp."

Cheryl Carmin, Ph.D., from the University of Illinois at Chicago, initiated the Saturday afternoon session with a presentation on co-morbid conditions that present with OCD, as well as treatment of OC spectrum disorders including hypochondriasis, body dysmorphic disorder, and impulse control disorders such as trichotillomania. Dr. Carmin spoke with clarity concerning principles and application of habit reversal, and participants learned when to implement habit reversal strategies in lieu of exposure and response prevention.

Saturday's session closed with a presentation by Dr. Pollard on treating individuals resistant to or ambivalent about OCD treatment. Participants learned the importance of avoiding power struggles with individuals who are not ready to engage in treatment. Most importantly, Dr. Pollard provided the clinicians with an integrated and practical heuristic to assist sufferers and their families when factors impede the sufferer's desire or ability to engage in treatment.

BTI Day 3: Case Consultation and Treatment Planning

In preparation for the BTI, participants selected a training case to present for feedback and guidance from the BTI faculty. Upon obtaining consent from the patient, the BTI participant performed an assessment of the patient's OCD symptoms, arriving at the BTI with the information in hand. Sunday's session began when participants were assigned in groups of 4-5 to individual BTI presenters or to Bradley Riemann, Ph.D., from Rogers Memorial Hospital and Throstur Bjorgivinsson, PhD., from The Menninger Clinic. Participants whose clinical interests focused on children and adolescents were grouped with faculty with child and adolescent treatment expertise. Likewise, participants with adult-focused clinical practices found themselves with faculty with expertise treating adults. Special efforts were made to place participants with others of roughly equivalent levels of treatment experience. This additional step optimized the comfort level and learning atmosphere within the small groups. In the small group in which this writer participated, the concepts and tools from the previous two days' presentations quickly paid dividends as members shared and analyzed their treatment efforts and challenges. The training cases substantially differed in depth and breadth of OCD symptomology, thus educating participants in applying treatment principles in situations beyond those encountered in their individual training case.

The final day the instructors integrated the material presented during the BTI, and remarkably and coherently synthesized the OCD treatment texts, OCD workshops, graduate school training, and ad hoc consultations/supervisions. The atmosphere of the breakout sessions was refreshingly open and participants eagerly asked questions and sought assistance with areas they struggled to understand fully. Over the next several months, participants will complete three subsequent consultations with their assigned BTI faculty member as they implement the treatment plans that they developed for their training cases. Upon successful completion of the additional consultations, BTI participants will receive their certification from the OC Foundation.

The OC Foundation and the BTI faculty strongly merit congratulations and thanks for their efforts in developing and coordinating a terrific training program. The numerous hours of administrative effort and academic preparation that the OC Foundation and the BTI faculty invest in this program are well spent and greatly appreciated.

It's Not Easy Being Clean

By Matthew Rahuba, B.S., and Hilary Zurbuch, M.S.
Western Psychiatric Institute and Clinic
Pittsburgh, PA

You walk into a room – spots, stains, uneven shelves, red paint on the floor, crooked posters, whirlwinds of scattered paper, unmatched chairs, crayons in the marker baskets, plastic sandboxes overflowing with old, dry pasta and rice; and, to top it off, one big communal bowl of grapes with no "Magic Soap" in sight. This may sound like no big deal to you, but for kids struggling with OCD this room is like a ferocious, fire-breathing dragon. This would be a room that they would do anything, including homework or eating lima beans, to avoid going into. However, this is exactly the room where the staff at the Western Psychiatric Institute and Clinic's Child and Adolescent OCD-Intensive Outpatient Program are helping kids face-off against dragons of all sizes every day. Why? Well, in Western Pennsylvania if you want to slay that OCD dragon, you gotta do battle with the dirt!

During the beginning weeks of our program, we teach our "knights" that the OCD is separate from the things that make them who they are, and they are not to blame for having it. To help our knights visualize this, we have them create a third person portrait and labels for their OCD, such as, a dragon or a monster. This concept, along with the Worry Hill Protocol and Fear Thermometer, designed by Aureen Pinto Wagner, Ph.D., was adopted into our program and the kids love it. The idea of our knights being a separate entity from their OCD dragons has really inspired them to take up arms against their OCD and battle it on all fronts.

After prepping our knights for battle by learning the nuts and bolts of exposure therapy, the time comes for them to march into the big battle – actually doing exposures. Our staff designs exposures to take on a fun and playful nature, which helps kids to be more interactive and involved in their treatment. We also include time in the daily schedule for group exposures, which typically consist of creative games and/or activities. For instance, we have created a game entitled "Garbage Pail Ball" in which each kid takes a ball, tosses it into the garbage can, and then we play a game of catch. One potential pitfall for our knights is that longer exposures seem to be less effective. Well, let's face it, kids get bored quickly! On top of that, long exposures are ripe for allowing that dragon to reverse the exposure. After all, we cannot let that creep sneak back in, can we? One technique we use to combat this issue is to change exposures quickly within the same symptom dimension. So, for example, to battle contamination fears, you may very well see our staff stop "Garbage Pail Ball" in the middle of the game and lead kids down the hall singing "Heads, Shoulders, Knees and Toes" while pantomiming with contaminated hands. These changes keep our knights alert and to keep that OCD dragon from rearing its ugly head in-between exposures.

Our program also encourages kid-initiated exposures. For example, we have set aside one group time per week for the knights to run their own exposures with minimal staff input. During this group activity, we have seen kids increase the difficulty of their exposures unprompted. Additionally, we have witnessed that peer support and/or encouragement have emerged from this kid-friendly group. We have seen them not only investing more in their own treatment but also in the treatment of their peers. It has been our experience that this creates an accepting and open therapy environment by removing the stigma of embarrassment and building a naturally stress-reducing atmosphere.

Now, of course we do not send our kids into battle alone. Our staff creates a nurturing and supportive environment designed to simulate, as best we can, real-life scenarios that would cause those dragons to roar. We believe that these "true to life" jousts help clad our kids in a battle-tested armor of support that will hold up to even the strongest of clashes. That way, if faced with even a slight skirmish, they can trust the skills that they have acquired from our guidance.

To show our knights in training that we practice what we preach, we are more than willing to ride along side of them into battle as their squires of encouragement. We participate in the exposures with our kids to keep them more active and group oriented while still tailoring each exposure to meet individual needs.

So, you ask, how does this all tie together? What do we do each treatment day? How do we make this combination blend together into one smooth daily schedule? Well, we just so happen to have an example of what our zany yet successful agenda may look like on any given day.

Battles Du Jour

4:00-4:15: Check-in, review homework

4:15-5:00: Dirty Art Therapy

Activity: Full hand contact finger painting

Objective: Target child's contamination fears and "just right" sticky thoughts

5:00-5:15: Snack/Recreation

5:15-6:00: Activity: Garbage Pail Ball "World Series"

Objective: Target kid's contamination fears and harming obsessions

6:00-6:15: Check out, assign homework

Using this combined approach, we have seen an average reduction of CY-BOCS scores of approximately 60% between admission to our program and discharge. We often receive feedback from parents describing how our program has eased tensions in their everyday lives and has, as they put it, given them back their child. To quote the mother of one of our recent graduates: "She is again my goofy, bright, loud, outgoing child with a heart of gold."

The next step in this on-going battle with the dark forces of OCD is to expand our program to include weekly E/RP based outpatient sessions. We now have the ability to implement this approach on more than one level of care to better serve "knights" with varying severity levels of symptoms. This also supports an essential component of care, which includes follow-up and maintenance for those "knights" that have graduated from our castle. In addition, we adapted our tactics to treat the littlest of "warriors," and we now accept patients from ages 4-18, which we split into two age groups. Our castle has the capacity to house 13 "knights" at any given time. For questions or referrals, you can contact us at (412) 488.4186.

Testimonials from a few of our "knights" and their parents follow:

"I hated it here at first but after Christmas and even late December to now it's okay. I didn't get why I just didn't wash my hands or use sanitizer to clean my hands or just change my clothes, but now I realize that it's so I don't feel like I have to do it and after a long time it worked. I am glad I came here in most ways now that I'm getting back my free time. I am glad I'm almost done here; here are some things I've beat: sheet on couch, 40 minute shower, sit on everything in my house now, sleeping in my bed and the evil sanitizer. Here are the things that ruin my life ...... NOTHING! Bye, bye, OCD!"
12 year-old Patient

"Thank you so much for the wonderful work that you've done with my son. Your caring and support for my son and our entire family will never be forgotten. You all are a miracle that entered our lives and turned what seemed like hopelessness into hope for a bright future. Thank you for bringing my son back to me."
Parent of a 16 year-old patient

"I think this place has helped me. I think the medicine has helped me also. I have had good snacks here. I have made new friends here. I have done a lot of exposures here. I think I am getting better at school. I have better hand writing. I am organizing better. I can stop myself from rituals now. I like the games here. I like to talk to my friends here. I like my binder. I like the chairs here."
9 year-old patient

"Through their effort, willingness and kindness my son is like a new person, and I can not thank the staff enough. I would highly recommend this program for anyone who needs help!!"
Parent of a 9 year-old patient

"It's not easy being clean when you have OCD."
9 year-old patient

Research Digest

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

The single most effective treatment for OCD is cognitive-behavior therapy (CBT) which combines exposure and ritual prevention with cognitive therapy. Serotonin reuptake inhibitor (SRI) medications also have proven benefit and are more widely available than CBT. Unfortunately, a few patients have severe OCD that responds little, if at all, to CBT and SRIs. For them, neurosurgery, transcranial magnetic stimulation and deep brain stimulation are sometimes helpful. Here we review recent reports of research on these experimental treatments.

Bilateral anterior cingulotomy for refractory obsessive-compulsive disorder: long-term follow-up results

Stereotactic and Functional Neurosurgery, 84:184-189, 2006, H.H. Jung, C.H. Kim, J.H. Chang et al.

This is an investigation of the long-term effectiveness and adverse effects of bilateral anterior cingulotomy. Seventeen patients with treatment-resistant OCD received neurosurgery at the Brain Research Institute in Seoul, South Korea. The Yale-Brown Obsessive Compulsive Scale and other neuropsychological tests were given before surgery and periodically up to 24 months after surgery. Eight of the 17 patients (47%) were responders. Interestingly, there was a delay in improvement for some patients: 29% of patients had responded at 6-month follow-up, 43% had responded at 12-month follow-up and 47% had responded at 24-month follow-up. Researchers suggest this delay in improvement is related to both the interruption and following reorganization of neural pathways. The reorganization process may occur a year or longer after neurosurgery, so improvement in OCD symptoms may take this long to emerge. Three patients experienced immediate memory dysfunction 2-3 months after surgery, but these complaints lasted less than 2 months. During follow-up, there were no significant adverse effects, including impairments in intelligence, memory or other cognitive measures.

Approaching treatment-resistant obsessive-compulsive disorder with brain stimulation interventions: the state of the art

Psychiatric Annals, 36:480-488, 2006, E. Hollander, R. Alterman and B. Dell'Osso

Approximately one-third of treatment-resistant OCD patients respond to neurosurgical techniques such as capsulotomy and cingulotomy. While considered effective, these neurosurgical procedures are irreversible and there are concerns about potential long-term adverse effects, such as personality changes. Several brain stimulation techniques are being investigated that are less invasive than neurosurgery. These OCD experts review evidence supporting the use of transcranial magnetic stimulation (TMS), deep brain stimulation (DBS) and electroconvulsive therapy (ECT) for individuals with treatment resistant OCD. Four TMS studies have been published with findings promising but inconclusive. In addition to case reports, effectiveness of DBS is supported by two small double-blind studies. DBS may be as effective as more invasive neurosurgery. The use of ECT in the treatment of OCD remains controversial. There are few published data, mostly single case reports, suggesting its use for OCD. ECT has been used for over 70 years. It is one of the most effective treatments for severe depression and could be useful in treating comorbid depression. A newer technique, magnetic seizure therapy (MST), is a form of convulsive therapy using a magnetic stimulus instead of an electrical stimulus as in ECT. MST is an experimental technique and has not yet been tested in patients with OCD. At this time, all brain stimulation techniques remain experimental and none has received U.S. Food and Drug Administration (FDA) approval for the treatment of OCD.

A functional neuroimaging investigation of deep brain stimulation in patients with obsessive-compulsive disorder*

Journal of Neurosurgery, 104:558-565, 2006, S.L. Rauch, D.D. Dougherty, D. Malone et al.

Neurosurgery (capsulotomy or cingulotomy) has been a last resort treatment for the most severe and treatment-resistant cases of OCD. An alternative to neurosurgery, deep brain stimulation (DBS*), is being studied in hopes it will be a more effective and safer treatment. DBS uses electrical currents delivered to the same brain areas that are surgery targets, at levels too low to produce tissue destruction. The ventral capsule/ventral striatum was the targeted area for electrical stimulation. Significant brain activation, measured by cerebral blood flow, was found in the orbitofrontal cortex, anterior cingulate cortex, striatum, globus pallidus and thalamus. This study has value in understanding the pathophysiology of OCD and the mechanism by which DBS may work. Please see the next review for results of this research.

** See article on page 7 about a person who has had DBS.*

Three-year outcomes in deep brain stimulation for highly resistant obsessive-compulsive disorder

Neuropsychopharmacology, 31:2384-2393, 2006, B.D. Greenberg, D.A. Malone, G.M. Friehs et al.

This paper presents the treatment outcome of eight adult patients with severe, treatment-resistant OCD receiving long term treatment with deep brain stimulation (DBS). DBS was performed at Butler Hospital in Rhode Island or at Cleveland Clinic Foundation Hospital in Ohio. Patients had stimulating leads implanted on each side of the brain into anterior limbs of the internal capsule. Battery-operated neurostimulators were placed in patients' chests and connected to brain stimulating leads by wires under the skin. Stimulation was continuous over the 3 years for 6 patients; stimulation was discontinued in two patients due to lack of adequate response. Four patients had significant improvement in their OCD symptoms and two others had partial responses. For responders, depression and anxiety also improved, as did self-care, independent living, and work, school, and social functioning. Most of the improvement occurred over the first months of stimulation and was retained throughout the 3 years. Additionally, researchers observed increased motivation to engage in behavior therapy, which all had attempted unsuccessfully before DBS. Researchers suggest this may have been a key factor in clinical progress. Although DBS was generally well tolerated, there were a number of adverse events. Adverse effects of DBS were separated into those relating to surgery, device failure, and the stimulation itself. Surgery complications included a small hemorrhage after a lead insertion, a single seizure during surgery and a superficial wound infection. The only device failures were device shutoff caused by metal detectors and expected interruptions because of battery depletion. OCD and depression worsened when stimulation was interrupted. When batteries ran out, after 5-13 months of stimulation, devices were replaced in outpatient surgery under local anesthesia. The adverse effects of stimulation included transient sadness, anxiety, and hypomania.

Repetitive transcranial magnetic stimulation (rTMS) in the treatment of obsessive-compulsive disorder (OCD) and Tourette's syndrome (TS)

International Journal of Neuropsychopharmacology, 9:95-100, 2006, A. Mantovani, S.H. Lisanby, F. Pieraccini et al.

Repetitive transcranial magnetic stimulation (rTMS) is an experimental treatment of brain stimulation with an electrical current. An electromagnetic coil is placed on the scalp. A high-intensity current is rapidly turned on and off (repetitive) in the coil and this produces a magnetic field that passes painlessly to targeted brain tissues. In this small trial conducted at Siena University in Italy, 10 patients with treatment-resistant OCD and/or Tourette's syndrome (TS) were treated with rTMS. Medications received for at least 12 weeks were continued throughout rTMS treatment and a 3-month follow-up. Over a two-week period, 10 rTMS treatments were delivered to each patient. Eight patients completed the study, 2 patients dropped out after the first week because they did not feel any benefit from rTMS. Three out of five OCD patients had clinically significant improvements in OCD symptoms and two out of three TS patients had complete remission of their tic disorder. Overall, 60% of patients had significant improvement in OCD and TS symptoms, with benefits lasting through the 3-month follow-up. No side effects were reported. Based on these positive results, researchers propose further study of rTMS.

The effect of repetitive transcranial magnetic stimulation (rTMS) on symptoms in obsessive compulsive disorder: a randomized, double blind, sham controlled study

Neuroendocrinology Letters, 27:327-332, 2006, J. Prasko, B. Paskova, R. Zalesky et al.

At the Prague Psychiatric Centre in the Czech Republic, 33 OCD patients participated in this controlled rTMS study. Patients had not responded to at least 8 weeks of medication treatment. They were randomly assigned to either active rTMS or to sham (fake) rTMS. Active rTMS was administered at a low frequency to the left dorso-lateral prefrontal cortex of the brain. Both sham rTMS and active rTMS were given in 10 daily sessions. Both treatment groups improved during the study period but there were no significant differences in response between the groups. Researchers concluded that rTMS was not effective in this study and they discuss reasons for this. Possibly higher frequency stimulation, stimulation of a different brain area or a greater number of sessions are needed.

Kelly Undergoes DBS

by Kelly F.

OCD started affecting my life when I was 25. It started with checking and slowly turned into mild contamination issues. A few years later OCD began its hold. In 1997 I was officially diagnosed with OCD.

I began taking 20 milligrams of paxil and the OCD was kept under control for many years. In 2000 my husband and I decide to have a child and I felt I could go off my medication during the pregnancy. By my fifth month symptoms did start to come back and by the last two months the OCD was becoming very difficult. It was a new kind of OCD. It was thought by my local doctors that after delivery I would go back on medications and thing would be fine. That didn't happen.

By the time my daughter was one, I had tried many medications and behavioral therapy with no response. The OCD was very different from before and hit hard and fast. The world in my view turned into a gross and contaminated place. I had to go though horrible routines to get items into the home. Food had to be transferred into containers, toys for my daughter had to wrapped at purchase, then washed before she could have them. Clothes had to be washed at my mother's before they could be washed at my home. I couldn't go outside; my husband had to take a shower if he stepped outside. At night, I had contamination dreams so intense that when I woke up I was in full OCD mode. It was a cycle that never stopped and was completely exhausting because I was determined to keep my daughter and OCD separate.

In January of 2002 my daughter and I went to spend some extended time with my brother and his family in Indiana. We thought maybe this could help break some of my routines and it would give my husband a much needed vacation from OCD. By this time I had been told by my doctors there was not much more they could do with medication. I decide to send emails to several doctors who specialized in OCD across the county asking for any help, guidance or possible research. The next day I was contacted by Dr. Wayne Goodman's office at the University of Florida, in Gainesville. There was something, Deep Brain Stimulation. Within two weeks my husband and I were in the car driving to Florida from Iowa.

After many tests and the approval process I was selected to be the first patient at the University of Florida to have DBS. Even though I was completely informed about the surgery and its risks, the details didn't matter to me. I was desperate. I didn't want my daughter to have to grow up with me the way things where.

I had my surgery in April of 2002. When I was told I would be awake during the brain portion of the surgery it never really sunk in until the procedure started. The sounds and experience of it were quite disturbing. When they had the first electrode implanted they started testing the settings and the feeling was unbelievable. I remember feeling very hopeful.

After recovering for four weeks, we went back to Florida to start the study. Since this was a blinded study there would be a 50/50 chance the stimulators would be turned on and I would not know either way for about month, only the neurologist, Dr. Okun, would know. As soon as I left the room, I knew the stimulators had been turned on. I remember walking out of the building and I felt peaceful and my husband said to me "I can tell by the look in your eyes there on."

After the blind portion of the study was over and we were informed that the stimulator had been on, now came the fine tuning. This is where they adjust the setting to find the right spots on the electrode. This was done every four weeks for many months. For me, brain surgery was nothing compared to this. It is almost indescribable the way it feels when they are adjusting the settings. It's not painful, just weird and, at times, very intense; but the end result is worth it. It seemed I got better just as fast as I had become debilitated by OCD.

Prior to DBS, OCD controlled every aspect my life. Now, four years later OCD is still a part of my life, but it is manageable. Most of the routines and rituals are gone. A few have been harder to overcome. I no longer have continuous dreams of being contaminated. I can work a little and spend time with friends. I now spend most of my time outside instead of inside during the summer months. Most importantly, I now can live a productive life with my family. I am extremely grateful for this life changing surgery and the continuing dedication of my doctors at the University of Florida.

Mayo Clinic Offers I
Cognitive-Beh

In the following interview, Dr. Autumn Braddock, Ph.D., talks about what has changed and what is the same at the the Mayo Clinic OCD Treatment Center since our initial interview several years ago.

NEWSLETTER: We interviewed the former director of the Mayo Clinic's OCD/Anxiety Disorders Program early in 2001. Have there been any changes in the program since then? What are the major changes?

BRADDOCK: There have been no significant changes to the treatment program since 2001. The administration has changed, with Katherine Moore, M.D., and I serving as the co-directors of the Anxiety Disorders Clinic.

NEWSLETTER: Is your OCD/Anxiety Program an Intensive Treatment Plan? Can patients also be seen for a differential diagnosis and weekly cognitive-behavioral therapy?

BRADDOCK: We offer comprehensive evaluations with a clinical psychologist and a psychiatrist who specialize in treating anxiety disorders, including OCD. Typically, patients are evaluated as part of a half-day, structured and unstructured diagnostic interview. Once an OCD diagnosis has been confirmed and it has been determined that cognitive-behavioral therapy/exposure and response prevention (CBT/ERP) is therapeutically indicated, the patient may choose to enroll in our program should slots be available. We have limited resources for therapy services but try to accommodate patients when appropriate. We offer intensive and weekly cognitive-behavioral therapy for all anxiety disorders.

NEWSLETTER: Tell me about Mayo's Intensive Treatment Program. How long is it? How many times a week is it? How many hours a day is it?

BRADDOCK: The intensive program is an outpatient program typically involving daily sessions for several hours for three weeks.

NEWSLETTER: How does your Intensive Treatment Program vary from your non-intensive treatment program?

BRADDOCK: The primary difference is the frequency of visits. The intensive program involves daily sessions; the non-intensive program involves one to two sessions per week.

NEWSLETTER: What treatment protocols do you use in your intensive program?

BRADDOCK: We offer only empirically-validated treatments at our clinic. For OCD, we provide cognitive-behavioral therapy/exposure and response prevention. Medication is offered when appropriate.

NEWSLETTER: Tell our readers something about your staff members and their background.

BRADDOCK: The Anxiety Disorders Clinic is comprised of a psychologist (me), a psychiatrist (Katherine Moore, M.D.), and a masters-level psychotherapist (Sarah Kalsy, MA., L.P.). All three of us have extensive training in treating anxiety disorders using empirically-validated treatments. Dr. Moore specializes in pharmacotherapy for anxiety, whereas Ms. Kalsy and I specialize in providing CBT for anxiety.

NEWSLETTER: Is anyone with OCD eligible or do you have limitations and exclusions?

BRADDOCK: Individual's presentations vary, but we typically offer an evaluation and treatment when possible to all individuals with OCD.

NEWSLETTER: Do you mainly use cognitive-behavior therapy and exposure and response prevention? What are your thoughts about the appropriateness of CBT and ERP?

BRADDOCK: CBT and ERP are the only empirically-validated treatments for OCD. Therefore, these are the only psychotherapies we use.

NEWSLETTER: Which, if any, medications do you use? Will you change a patient's medication if s/he is not getting the maximum relief? How do you make this determination?

BRADDOCK: When therapeutically indicated, medication is utilized. Dr. Moore conducts a comprehensive assessment in order to determine the appropriateness of medication and takes into account the individual's past experiences (if any) with previous medication trials. Most often, our patients are on selective serotonin reuptake inhibitors (SSRIs) and in CBT/ERP.

NEWSLETTER: What will a patient experience on his/her first day in your program? Will they immediately begin doing ERP?

BRADDOCK: First, a comprehensive half-day evaluation is conducted by Dr. Moore and me. Formal and informal assessment methods are utilized (e.g., interview, self-report measures, theYale-Brown Obsessive Compulsive Scale). Typically, treatment does not begin immediately unless previously arranged. If a therapist is availalbe, patients can begin CBT/ERP at their next appointment. Treatment typically involves a functional assessment of the OCD symptoms, psychoeducation, cognitive therapy, and exposure and response prevention.

NEWSLETTER: What's a typical day for a patient in your intensive program?

BRADDOCK: Days vary, but typically patients will be seen for two to three hour appointments per day. They meet one on one with a therapist.

NEWSLETTER: How many people are in the program at the same time?

BRADDOCK: It varies. All work is individual; we do not offer groups.

NEWSLETTER: Do you only allow adults into your intensive program? What treatment do you have available for adolescents and children with OCD?

BRADDOCK: Our program only treats adults. For children and adolescents, check out the Mayo Clinic Child and Adolescent Anxiety Disorders Program. Steve Whiteside, Ph.D., is the director of this program.

NEWSLETTER: How long does a

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typical OCD sufferer stay in the program? Is there a set protocol s/he has to work through? What if the person is making progress but still needs more intensive treatment? Will you keep him/her in the program until s/he can manage his/her OCD effectively?

BRADDOCK: Typically, patients are seen for 16 sessions with the non-intensive program and for 3 weeks for the intensive program. Research has demonstrated that maximum treatment effects emerge by this point. Should the patient need additional treatment, accommodations can be made.

NEWSLETTER: Are patients' treatment plans individualized?

BRADDOCK: Yes.

NEWSLETTER: Do you have support groups and other meetings on a daily basis so that patients can work together and help each other?

BRADDOCK: No.

NEWSLETTER: Do you have inpatient facilities for OCD sufferers who are in the Intensive Treatment Program?

BRADDOCK: No.

NEWSLETTER: Where can a patient stay who is from outside a convenient commuting distance? Does The Mayo Clinic have a special rates agreement with local hotels?

BRADDOCK: Rochester has numerous hotels conveniently located near The Mayo Clinic. This website has information about becoming a patient here: http://mayoclinic.org/becomingpat-rst/.

NEWSLETTER: If a patient is having severe difficulties while enrolled in the treatment program, are there options for hospitalization at Mayo?

BRADDOCK: Should a patient become a danger to himself or others, hospitalization is always an option. We do not offer inpatient OCD treatment.

NEWLETTER: How do you involve the family in the treatment regime? Do you have educational meetings for them?

BRADDOCK: With the patient's consent, family members can be involved in treatment. Most often we provide a summary of the treatment to relevant family members and discuss how they can be supportive of the patient's treatment needs.

NEWSLETTER: OCD is a chronic disease; what do you do to prevent relapse?

BRADDOCK: A goal of CBT is to teach the patient how to use a skill-set which can be applied in his/her everyday life to handle the obsessional anxiety and urges to engage in compulsive behavior. Therefore, exposure exercises relevant to the patient's real-life experiences are conducted (i.e., outside the office). Independent practice (i.e., without the therapist present) of the cognitive techniques and exposures exercises is encouraged. This helps maintain treatment gains. Problem-solving post-treatment difficulties occur toward the end of treatment. Booster sessions are offered through our clinic to local patients; referrals for CBT/ERP therapists close to the patient's home are provided when available.

NEWSLETTER: Do you have a separate program to deal with treatment refractory OCD?

BRADDOCK: No

NEWSLETTER: What do you do when a sufferer has a comorbid condition such as bi-polar disorder or ADHD? Will you treat all conditions at the same time?

BRADDOCK: We only treat OCD at our clinic. Should additional treatment be needed for comorbid conditions, we offer referrals.

NEWSLETTER: Will you admit someone into the Intensive Treatment Program if s/he has a substance abuse problem?

BRADDOCK: Not if the substance abuse is ongoing.

NEWSLETTER: Will most private insurance plans cover your Intensive Treatment Program? What about Medicare and Medicaid?

BRADDOCK: Typically yes, but it is the patient's responsibility to ensure that his/her insurance will cover the program.

NEWSLETTER: Do you have any treatment scholarships available?

BRADDOCK: No.

NEWSLETTER: Have any papers been published on your projects? Can someone get intensive treatment if s/he volunteers to be in one of your treatment trials?

BRADDOCK: Currently, we do not have any ongoing treatment trials. Under the direction of the former director (Jon Abramowitz, Ph.D.), numerous studies were conducted through the clinic. The research has been presented at national conferences (e.g., the Association for Behavioral and Cognitive Therapies and the Anxiety Disorders Association of America) and has led to more effective treatment of OCD.

NEWSLETTER: Who should someone get in touch with if s/he is interested in learning more about your program or thinks that s/he would like to take part in your program?

BRADDOCK: If you are interested in being evaluated at Mayo through the Anxiety Disorders Clinic, please contact me: Autumn Braddock, Ph.D., at 507-284-5849.

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Houston Family Striv
Obsessive-Comp

By Laura Duffy

"McIngvale" is a household name throughout Houston, Texas. As the owner of Gallery Furniture, one of the largest retail stores in the U.S., James McIngvale makes regular appearances in the homes of Texans via his store's popular television ads. Mr. McIngvale and his wife, Linda, are just as renowned, however, for their involvement in local and national causes, and especially for their philanthropy.

photograph by Bill Truslow

James and Linda McIngvale

A very personal situation for this public couple – their daughter Elizabeth's diagnosis with obsessive compulsive disorder (OCD) – has inspired the McIngvales to take on this condition. OCD, which affects two to three percent of the population, tends both to dominate and limit the lives of those who suffer from its deeply troubling symptoms.

Despite their daughter's serious illness, Mrs. McIngvale says that she and her husband nonetheless feel fortunate. "Liz was diagnosed early – at around age 12 – so we got her into cognitive behavioral therapy [CBT] at a fairly young age," Mrs. McIngvale explains. Many people with OCD hide the recurrent, unwanted thoughts (obsessions), such as the fear of contamination, and the repetitive behaviors (compulsions), such as hand-washing, that characterize the disease. An additional benefit for the family was the fact that Liz, fortunately, unlike many OCD sufferers, was able to verbalize and let her mother know what she was going through. "I was lucky my kid was open with me," says Mrs. McIngvale.

Even though she has benefited from access to outstanding psychiatrists who are seasoned CBT practitioners, Liz, now 19, continues to struggle with her condition. This is the nature of OCD, her mother notes. "If we see Liz controlling her condition, we assume she's doing great," says Mrs. McIngvale. "But she has to manage it on her own, and that is a daily challenge. I wish people understood the depth of the suffering that comes with OCD."

The McIngvales do understand the magnitude of the disease, and their instinctive innate generosity has moved them to do something about OCD, which affects 2-3 percent of the population. The family's goal of supporting promising research aimed at finding a cure for OCD led Mrs. McIngvale to Michael Jenike, MD, a psychiatrist at the Massachusetts General Hospital who specializes in OCD. "Dr. Jenike described the team of experts he would organize, and

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▲*This research is financed by the McIngva*

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how they would approach the research," Mrs. McIngvale recounts. "We were very impressed."

The McIngvales have made a generous commitment of $10 million to sponsor a major, sustained OCD initiative at Massachusetts General Hospital. In response, Dr. Jenike formed the McIngvale Research Group – a team of specialists in psychiatry, genetics and imaging who have turned their collective focus to OCD. At the core of the research program is a cohort of 400 families, all of whom have a child with the condition, Dr. Jenike explains.

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"We know that OCD runs in some families," he says. "These families are providing us with a way to compare individuals who have OCD with family members who are at risk for the disorder. If we can identify what the genetic problem is, we will be able to understand what is going on in the brain."

The potential implications of the McIngvale Research Group's work are vast. The identification of the genes that are associated with OCD potentially will lead to a key diagnostic test; provide clarity about the chemical imbalance that occurs as a result of OCD; and, ultimately, produce improvements in OCD treatment. Such treatment, McIngvale Research Group investigators hope, will involve – medication as well as CBT, which focuses on training the affected person to believe s/he can safely refrain from his/her compulsions.

The progress made by Dr. Jenike and his team has been thrilling, says Mrs. McIngvale. "The strides they are making are just phenomenal to us," she says. "I believe they are going to identify what causes OCD and hopefully find a cure. As I told my husband, our support for this research is the best money we've ever spent."

Dr. Jenike says that the McIngvales' platform of research support is allowing the group to study OCD in new ways. "The funding they have provided not only has helped us to focus, but it also is encouraging us to be creative in our approach to OCD," he emphasizes. "For example, we are studying neurotransmitters that we never considered before, on the chance that they may play a role in OCD symptoms."

At home in Houston, the McIngvales are doing everything possible to help others with OCD, including funding local treatment programs. Liz, now enrolled at the University of Houston, has followed her parents' lead by establishing the Peace of Mind Foundation, whose goal is to provide funds to individuals with OCD who cannot afford treatment. Liz also serves as a spokesperson for the Obsessive Compulsive Foundation's new public service campaign, which poses the question: "What does OCD look like?" The campaign is intended to raise awareness while simultaneously neutralizing the stigma attached to OCD.

"Liz takes after her mother; she's valiant and courageous," Mr. McIngvale proudly notes. "When I see how she is dealing with her disease, it makes me feel we raised her the right way. She wants to help other people, and that is the most important thing you can do."

** This article has been reprinted with the expressed consent of the MGH 2005 Donor Report in which it first appeared.*

HOW CONNOR GOT THE BEST

AND HIS MOM STARTED A SUPPORT

by Marie Shamberger, Connor's mother

Our story begins on November 1, 2004, when our 8-year old son Connor was in third grade. That is the day that his OCD symptoms exploded and hit our family like a freight train. Just a few weeks prior to his OCD really flaring up, I had suspected that Connor had OCD. Now we were in an acute crisis. At the time, I was aware of OCD, but I certainly did not know his OCD. I felt I had to know his OCD in order to help my son fight his battle, and, ultimately, win.

In the beginning, Connor was practically disabled from the OCD. He couldn't get dressed or get through his morning routine. He was convinced that I was cooking and serving him poison. A drop of water or a drop of milk would spiral into an acute meltdown. The rituals were the most terrifying; he seemed addicted to them. I could see that the washing rituals brought him pleasure and temporary relief. For me, this was horrifying to watch, partly because I did not understand it at all. OCD was an invisible bully and it had no mercy for my son.

I was afraid to tell anyone about my son's behavior. I was afraid because he was now "mentally ill." I was afraid that even close friends and family would not understand.

We read books from the library about OCD, but they were mostly outdated, depressing, and bleak. We did not know about current OCD research, the existence of the Obsessive Compulsive Foundation, the chances of a great prognosis, or the existence of ERP (Exposure and Response Prevention). We started him on an SSRI and hoped that it would work. We felt as though we were treading water while waiting to see our first therapist. Ever so slowly, Connor began to improve. I also began to understand what OCD really is: a neurobiological medical disorder that causes a chemical imbalance in the brain.

In the meantime, I was interested in meeting and getting to know adults with OCD, for this might help me to see what his future would be like. I contacted Susan, the facilitator of an OCD/scrupulosity support group in Akron/Canton, Ohio. I started attending adult support group meetings and continued to learn about OCD. Sue put the first "bug in my ear" about starting a group for parents. At the time, however, I still felt like we were on thin ice. Connor was still fighting and his OCD was still quite strong.

The concept of starting a support group always seemed like the right thing to do. However, the timing had to be right. Dealing with and helping Connor was a full-time job; it was exhausting to endure meltdowns, to keep ahead of OCD's continual morphing attacks, and to develop new strategies to fight his OCD.

Fortunately, with appropriate ERP therapy, things really started to settle down during the summer of 2006 – months shy of the onset of Connor's OCD symptoms two years before. With Connor more settled, we now had more time available to spend quality time with our youngest son. Previously, Connor's OCD symptoms took up most of our time and attention; and it was common to ask our youngest son to "go and do something else now" or "please leave the room now."

This was the time to begin the support group. I decided to wait until school started in the fall and then began formally organizing the support group. This is where the work started. Sue's adult OCD support group was going into its seventh year, so Sue and I worked with one another to market both of our groups together. We came up with a joint cover letter and mailed information about our individual groups to local psychiatrists, psychologists, therapists, and counselors.

By this time, I was in the process of securing a meeting room for the parent meetings and, at the same time, contacting psychological, and counseling/therapy practices to let them know about the new support group. I received a surprising response when I phoned Georgette Constantinou, Ph.D., director of the Division of Pediatric Psychiatry and Psychology at Akron Children's Hospital. After meeting with Dr. Constantinou, I was given permission to use Akron Children's facility for our support group meetings. Dr. Constantinou said, "The hospital is committed to partnering with the community to try to develop more therapeutic resources for children with OCD." While Akron Children's Hospital is not directly involved with our meetings, its staff has been able to offer their support for our group in other ways: they were able to offer a room for our meetings, a library for our donated OCD literature and OCD videos, and permission for us to display our support group fliers in their information booths.

This OCD parent support group began with much support from Sue, some local OCD moms, and Connor's therapist. I did make another contact via the OC Foundation web site; I "met" Lisa, who runs a support group for OCD parents in Plano, Texas. Lisa was able to give me a good idea of what to expect from the meetings and, over the course of this past year, we have spoken many times about our children, OCD, ERP, support groups, and the OC Foundation.

Prior to the first parent meeting, I was able to e-mail a handful of parents in order to inform them of the meeting date and time. One parent contacted me after receiving the mailing and stated that she lived too far to attend the meetings. She asked that I remove her from the mailing list, unless I thought there would be something interesting about OCD that I could send via email. This is where the concept for my monthly OCD Parent E-Newsletters started. This monthly e-newsletter list has gone from about 20 to over 130 interested OCD parents and professionals. I have since encouraged both OCD parents and children to tell their stories. Local therapists have also written articles for my newsletter.

Even though my son is very close to being in an OCD remission (if you will), I remain passionate about educating parents, the public, and professionals to the best of my ability. I, along with my son's current therapist, Gabrielle Faggella, LISW, ACSW, have done a joint resident physician in-service entitled, "The Identification and Treatment of OCD in Primary Care." I have done

OF OCD GROUP

classroom in-services ("OCD in the Classroom"), and am scheduled to do other public in-services and professional presentations about OCD in the near future.

OCD is a terrifying and horrible experience for anyone to go through, especially a child. The existence of the support group is a way to "throw a life preserver" to a parent or family in need of support or access to the best OCD information, such as, the OC Foundation and books that have been recommended by parents. Parents often attend our meeting just to learn more about OCD. Usually, either their child has just been diagnosed or they want to learn more because they think their child may have OCD.

In the ten months since I formed the support group, attendance at the meetings has ranged from three to eight people. There are mostly different people from month to month, with some repeat attendees. Attendees range from being in an acute crisis, to those simply seeking information. I think this helps the group stay focused on the individual issues that OCD presents.

This support group has been a project I have fully embraced. Being the only Parents of Children with OCD support group in our state has meant that this enterprise has covered some new ground and tackled some difficult issues. I realize that it would not have come off so easily or so well without the assistance and guidance of other experienced support group facilitators, mental health professionals, and even our local children's hospital. When I first started dealing with OCD in my child, I had a hard time finding the information I needed to help him get on the right path to recovery. A support group is probably the most effective way for OCD awareness at a local level to begin. It's so very important to have this forum so that people who are in crisis can at least have someone throw them a lifeline.

To quote my son Connor, "It really, really stinks having OCD; but if we can help other people, we can at least try to make something good from it."

Thank you for reading our story!

TREATING OCD AND SUBSTANCE ABUSE IN A COLLABORATIVE TEAM APPROACH

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

In recent years, the Westwood Institute for Anxiety Disorders, Inc. has received an increasing number of inquiries regarding treatment for OCD co-occurring with substance abuse. The substance abuse in many of the inquiries resulted as an attempt to self-medicate for the intolerable anxiety generated from the obsessions and compulsions. Since the most apparent symptoms tended to be the addictive behaviors of substance abuse, patients often received only treatment for their alcohol and/or drug addiction without having their OCD symptoms addressed. Consequently, patients relapsed and returned to substance use in an effort to decrease the ensuing anxiety from their OCD symptoms that were not treated sufficiently.

Due to the lack of an integrated treatment approach for patients suffering from OCD and substance abuse, the Westwood Institute has recently joined efforts with the UCLA substance abuse program headed by Dr. Roger Donovick to provide a comprehensive team treatment modality. The following are three cases that received conjoined treatments with the goal of providing a more thorough regimen.

Case 1 involved a 24-year-old student with some obsessive compulsive symptoms that were never diagnosed. The patient had a history of minor surgeries and was prescribed painkillers following each surgery. However, trauma from previous surgeries and fear of the subsequent surgery exacerbated his OCD symptoms. As a result of the intolerable anxiety and fear, the patient began depending on the painkillers not only to reduce pain but also to decrease the discomfort from the obsessions and compulsions. The patient also had Social Phobia and often feared being evaluated by peers and professors. His perfectionistic fears would often lead to overwhelming distress when completing academic assignments. He was able to access the painkillers continuously, which kept him dependent on them. However, he would often skip school because of grogginess from the painkillers. Eventually, the patient dropped out of school due to the increasing level of anxiety and fear of evaluation.

The patient sought help from many rehabilitation centers for his drug abuse, but all were unsuccessful. During his initial evaluation at the Westwood Institute for Anxiety Disorders, Inc. in May 2005, the patient indicated that the painkillers would not be abused if he did not experience anxiety from his obsessions and compulsions. Thus, the Westwood Institute teamed up with Dr. Donovick at the UCLA substance abuse program to treat the patient conjointly. Drug withdrawal was very complicated and severe. The patient was often very sleepy and incomprehensible. Nevertheless, OCD psychoeducation was conducted during the drug withdrawal period.

Following the withdrawal period, the OCD treatment commenced intensively for nine days at the UCLA inpatient alcohol abuse unit while Dr. Donovick's team continued to monitor the patient and his medications. Exposures to perfectionistic fears were conducted via loop tapes, writing self-narratives about making errors and failing, and having the patient make purposeful mistakes. Upon completion of the substance abuse program, the patient was discharged to outpatient care at the Westwood Institute for another 11 days, in which his social phobia and fears of surgery were targeted. The 6-month and 12-month follow-up evaluations revealed that his treatment gains had been maintained, and the patient had returned to school.

The second case involved a 26-year-old female with obsessive fears of harm happening to herself and others. The patient would consume alcohol heavily and become intoxicated daily in an effort to escape her intrusive thoughts. She had undergone several substance abuse treatments, but relapsed each time. The patient was never diagnosed with OCD; and thus, her symptoms were never addressed. She became aware of her obsessive compulsive condition after watching a television documentary about OCD on MTV, and contacted the Westwood Institute for Anxiety Disorders, Inc. for further information. Following her initial assessment in September 2005 it was found that the patient's self-diagnosis was accurate, and she earned a score of 36 on the YBOCS. She was admitted to the UCLA substance abuse program and was closely monitored by Dr. Donovick's team during her 7-day withdrawal period. Following the withdrawal period, she was discharged to outpatient treatment at the Westwood Institute for 2 weeks of intensive OCD

(contined on page 16)

Information Hoarding: The Ne

By Renae M. Reinardy, Psy.D., LP
Lakeside Center for Behavioral Change
Minnetonka, MN

Compulsive hoarding is a condition that comes in a variety of forms. I refer to them as the "flavors of hoarding." In general, hoarding is a condition that affects millions of Americans and their families. A number of my clients who hoard have been self-referred for treatment, but many others had another person or organization demand that they seek treatment. In either case, I have found that many hoarding clients are able to make progress. Many hoarders have felt much shame about their condition and have said things like, "I must be so sick to be doing this behavior." I will agree if by "sick" they mean: S-sensitive; I-intelligent; C-creative; and K-kind, since these are the characteristics I so often find in my clients who hoard.

As I mentioned, hoarding comes in different flavors. This includes different ways that people come into possession of the types of items acquired, and the reasons why people have difficulties processing their possessions.

Items can be acquired in a number of ways. This is the "How." Some examples include compulsive shopping, picking up free items, inheritance, gifts, the Internet, and gradual accumulation over many years. There is also variation in the types of items that are acquired and saved. These are the "What." Examples include, clothing, animals, tools, machines, crafts, containers, food, recyclables, sentimental possessions, and varieties of media containing information. There are many reasons why individuals hoard (the "Why"), but often cognition processing deficits and emotional attachment to possessions are contributing to the behavior. Other common factors may include depression, attention deficit disorder, a family history of hoarding, control issues, or perfectionism.

The focus of this article is on the information hoarding subtype. Within this "flavor" of hoarding, it is important to look at the types of information that people feel compelled to acquire and save, and the thoughts and behaviors that often fuel this need to know. The categories include memory items, research items, and general knowledge items.

Memory items can be pieces of information that remind us of important events or people in our life. Many information hoarders will save calendars that have been used or have intended uses in the future. People often get a backlog of information entered on their calendars and feel compelled to remember the information, even if it occurred several years ago. Greeting cards and gift lists are also frequently saved items, with the intention to track these items. Lists in general are also often kept detailing things to do and things that have already been done. Several of my clients have kept time records, video recordings, and audio recordings of events that they perceived to be important, but many others would not. Sticky notes and computer pop-up reminders are also memory tools that can be used excessively with individuals with this hoarding subtype. Also common to memory items are previously read materials that are believed to be important enough to keep in case the information is needed in the future.

Research items include information that is sought out for a specific purpose. Common sources for this information include researching on the Internet, books, magazines, newspapers, "Consumer Reports," and asking questions of friends and family. Research items are often acquired either with the intention to help the individual make some type of decision or for general interest. People with this type of hoarding will often research items for days or weeks with the intention of assisting them in making the "right decision," regarding home appliances, doctors, home repairs, where to travel, employment opportunities, and volunteer positions. They are often trying to reach the experience of "fully knowing." Many people will do research when making an important decision, but with hoarding this process is much more laborious than is often necessary. Information hoarders may enjoy this process or feel tortured by their feeling of "needing to know." This process can lead to hyper-focus – that's when individuals will research for continuous hours without realizing the time or taking care of basic needs (e.g. sleep, eating, family time, etc.).

The last category I will discuss here is general knowledge hoarding. This is information that is not actively sought, but seems important to know or remember. Common items that fall under this category include public safety flyers (e.g., winter driving tips, home ownership tips, how to recognize a stroke, etc.), current events, community events, and information that is specific to that individual or others close to him/her. What is important to keep in mind is that much of this information is interesting or is potentially useful; the problem is with the quantity of information, which makes accessing it extremely difficult, and the distress or impairment caused by this behavior. In addition, people who hoard often have too broad a scope of interests. This results in the desire to learn more about multiple things, often never being able to satiate their curious minds.

Many information hoarders are resistant to changing their behavior because they are afraid that treatment will "dumb them down," or they will lose their creative edge. I have yet to see this occur in therapy. Clients typically report the opposite, where they find they are better able to focus and that they are more likely to complete projects. Instead of taking a "do it all at once" approach, we work on breaking down interests and information based on importance, priority, and reasonable limits.

What is fueling the need to know and remember? The answer to this question often includes three parts. Assessment of the behavior typically involves looking at thoughts, behavioral patterns, and reinforcers that are maintaining or exacerbating the hoarding problem.

There are several thought patterns identified in individuals who hoard. These patterns have been discussed in more detail in the research done by Frost and Steketee (1998), who have been the pioneers in hoarding literature. Hoarding thoughts can be related to perfectionism (e.g., a perfect person

ed to Know and Remember

would remember this information), over-commitment (e.g., I will research that for you), beliefs about memory (e.g., everyone else can remember what was written in the "Washington Post;" I need to save it because I cannot remember it all), opportunities (e.g., this information can change my life), and the importance of information (e.g., any moral person should know this).

As human beings we often fall into daily routines, and we develop behavioral patterns. For people who hoard, these routines may include hours of research each day, or going to the local coffee shops to pick up newspapers that others have left behind. It is important to observe these patterns and not get caught in "autopilot." Autopilot is when we do not really observe or challenge any of our daily routines, but just go about doing the behavior whether it is adaptive or not. By increasing awareness of behaviors we are able to shift out of autopilot and make more conscious decisions on what is best for ourselves and our families.

Changing thinking and behavioral patterns are often essential in producing change, but another important component is not losing enjoyment during the change process. This is why it is important to understand reinforcement and replacement as they relate to a person who hoards. Many hoarders do enjoy aspects of their hoarding behavior. When it is taken away they may feel a void and eventually fall back into familiar acquisition and saving behaviors to cope with that empty feeling. An important component in successfully treating hoarding is asking the question, "What do you get out of this behavior?" People will answer this question in different ways, but often they engage in the behavior because it feels good to help others, they like to look/feel intelligent, they want to achieve a sense of security by decreasing uncertainty, and/or they want to avoid anxiety by not making a final decision.

As with other types of hoarding, there are many consequences that can result from this behavior. The more obvious consequences of information hoarding can be cluttered living space, loss of time, procrastination in decision-making, work stress, and stress in the family. Less obvious consequences include cyber-clutter and not being able to move on in life. Cyber-clutter can occur in individuals who do not have visible clutter in their home or workplace but have thousands of pieces of information saved on the computer or on CDs. Many information hoarders also get stuck in life because they are still gathering information on what they want to do, but never achieve the sense of knowing needed to actually make the decision to do what they desire.

"Okay, sounds like me. Now how do I change?" Just as information hoarding is a complex behavior, therapy needs to be multifaceted and meet individual goals and needs. Typically treatment will include exposure and response prevention (ERP) and cognitive restructuring. With ERP, individuals learn the skills to make decisions in a "just wrong" way, or at least it may feel that way in the beginning. This can include limiting research and making decisions at less than perfect times. Ultimately, this is exposure to the unknown and the "what if." It is helpful to work on developing a hierarchy with your therapist to start with easier exercises and working up to more difficult ERP activities. Response prevention is not engaging in "fix-it" behaviors to decrease anxiety by feeding the need to know. An example of this is not reordering a book that you donated, or substituting hours of looking at the newspaper on your sofa with hours of looking at the newspaper on-line.

Cognitive restructuring often includes shifting out of autopilot to identify, challenge, and replace hoarding beliefs. This begins with self-monitoring to look at the thoughts that automatically come to mind when dealing with acquiring or attempting to make decisions on information items. Once those thoughts are identified, clients are encouraged to challenge the thoughts by asking, "Is that really true," or "How likely am I to really need that information?" Finally, after identifying and challenging a hoarding belief, clients learn replacement thoughts such as, "I have kept information like this for years, but I really do not use it, despite my good intentions." This process typically helps individuals improve decision-making skills and decreases the amount of procrastination, stress, and clutter in their lives.

Treatment is also more likely to be successful when reinforcers and replacements are considered and individuals are provided with experiences in therapy to practice their newly acquired skills. In order to decrease the feeling of loss during the change process, therapy should look at the reinforcers of the behavior and provide more adaptive ways to get the hoarder's needs met. One client I worked with had much difficulty with information hoarding related to reading and saving books. We discovered that it served the function of adventure and excitement for her. The key to successful treatment included learning outdoor activities such as kayaking. She was able to get this adventure need met in other ways, which made it easier for her to put limits to the time she spent reading and the number of books she acquired and saved.

Allowing clients to practice their skills in the session is also extremely helpful. This can be done in the therapist's office, during a therapy home visit, or in homework assignments during the week. It is important to emphasize that this is a skills-based approach. As with any skill that we learn, we will lack ability in the beginning; but if we break down goals into reasonable steps and keep practicing, skills improve and the process becomes easier.

The aim of this article is to help people better understand this subtype of hoarding and the components typically found in treatment. There are many similarities across the different flavors of hoarding, but there are also several important differences that need to be considered in the treatment of this condition. Due to much effort by a number of researchers and clinicians, hoarding behavior is now beginning to be better understood by the scientific community, which has led to several major advancements in the assessment and treatment of this behavior.

Dr. Reinardy is the President of the Lakeside Center for Behavioral Change, P.C., and specializes in treating children, adolescents and adults with OCD, trichotillomania and related conditions.

TREATING OCD AND SUBSTANCE ABUSE

(continued from page 13)

therapy to target her intrusive thoughts of harm. At the conclusion of treatment, the patient earned a score of 6 on the YBOCS. At the 12-month follow-up, the patient remained asymptomatic and was able to hold a full-time job.

The third case involved a 25-year-old male who abused alcohol and amphetamine. The patient was diagnosed with OCD and experienced severe anxiety from fears of failing, being criticized, and homophobic concerns. However, his previous therapist never associated the substance abuse with his OCD symptoms. The patient had undergone six rehabilitation treatments at various substance abuse programs before contacting the Westwood Institute. During his initial evaluation in April 2006, the patient earned a score of 33 on the YBOCS, and acknowledged using substances in an attempt to decrease the distress caused by his fears. He spent 9 days at the UCLA substance abuse program in which he was treated for substance abuse withdrawal by Dr. Donovick. Towards the last 5 days of inpatient care when he was more responsive and able to focus, cognitive-behavior therapy (CBT) was used to address his OCD symptoms. Upon discharge from the UCLA substance abuse program, the patient continued his treatment in the outpatient intensive OCD program for another 15 days at Westwood Institute. At treatment termination, the patient earned a score of 9 on the YBOCS. The patient remained asymptomatic with both OCD and substance abuse at the 6-month follow-up, and his functioning had increased 90%.

In all three cases, treatment was successful due to the fact that each case was not only treated by a team of specialists in substance abuse and OCD, but the treatment was integrated, comprehensive, and tailored to each patient's needs and conditions. This year, the Westwood Institute received 12 inquiries from family members of OCD patients abusing substances to self-medicate. Although it is increasingly apparent that this population exists, the issue of this comorbid condition is less frequently addressed. The success of these cases involving OCD and substance abuse will largely depend upon the level of collaboration and comprehensiveness of treatment provided by each specialist. When symptoms are treated separately, treatment has not been as successful because mutual goals are not addressed. A conjoined team effort approach will address patient issues that would otherwise be overlooked.

Bulletin Board

(continued from page 2)

identify and describe specific genes that may cause complex diseases such as OCD. We are seeking families with OCD to help us conduct these studies.

You Can Help! If at least two members of your family are diagnosed with OCD or exhibit symptoms, your family might be eligible for this nationwide study. Participation includes a confidential interview and a blood sample. The interview will be scheduled at a time and place convenient for the participant. Participants will be compensated.

Your Help Counts! Each participant's help is vital and DOES make a difference. Families may be referred by a clinician or may contact us: Krista Vermillion (410) 426-4822, or Dr. Jack Samuels, at jacks@jhmi.edu.

OCD RESEARCH AT THE U.S.-MEXICO BORDER

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

Are you?

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

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

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

OCD TREATMENT STUDY FOR CHILDREN AND ADOLESCENTS

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

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

Dr. Paul Grant, MD, a child and adolescent psychiatrist, is the Principal Investigator. For further information please contact Lorraine Lougee, LCSW-C at 301-435-6652 or Matthew Hirschtritt at 301-496-5323, or email OCDNIMH@intra.nimh.nih.gov.
This study is run by the National Institute of Mental Health, National Institutes of Health, Department of Health and Human Services.

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

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

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

If you are interested, please contact Margo Thienemann, M.D., at mthiene@stanford.edu or 650-723-5383 or Sarah Forsberg at sarah523@stanford.edu.
For further information regarding questions, concerns, or complaints about research, research related injury, and questions about the rights of research participants, please call 650-723-5244 or call toll free 1-866-680-2906 or write the Administrative Panel on Human Subjects, Medical Research, Administrative Panels Office, Stanford University, Stanford, CA 94305-5401.

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

The goal of the study is to evaluate how a new drug with an innovative mechanism of action (decreasing glutamate in the brain) affects anxiety. We offer participants a free research evaluation of his/her anxiety. This study is 12 weeks and includes 5 visits. The first 4 visits occur every other week and the final visit occurs one month thereafter. Namenda is dispensed at Visit 1 and titrated to a maximum daily dose of 20 mg by Visit 3. Compensation is $15/visit and UCLA parking vouchers will be provided. Namenda is an FDA approved medication, but not for the treatment of GAD. If you are interested in participating in the study or finding out more about it please call: (310) 794-1038.

University of Florida Research Study

Do you repeatedly check or arrange things, have to wash your hands repeatedly, or maintain a particular order? Do unpleasant thoughts repeatedly enter your mind, such as, concerns with germs or dirt or needing to arrange things "just so"? If this sounds familiar, you may have a treatable problem called obsessive compulsive disorder (OCD). Past research has found that a form of therapy, namely, cognitive-behavior therapy, is helpful in as many as 85% of people with OCD. Researchers at the University of Florida are interested in determining if adding a medication called D-Cycloserine improves the effectiveness of cognitive-behavior therapy in adults with OCD.

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

If interested, please contact Dr. Eric Storch at (352) 392-3611 or estorch@psychiatry.ufl.edu. *This study is funded by the OCF Research Fund Award Program.*

OCD and Hoarding Study

The Institute of Living in Hartford, CT and The Boston University School of Social Work are conducting research to understand the features of obsessive compulsive disorder and compulsive hoarding. The study compares people with hoarding problems to those who have obsessive-compulsive disorder (OCD). It is not necessary for participants to have hoarding problems or clutter to participate. The researchers hope to learn more about why hoarding and obsessive compulsive symptoms develop, how these problems are related to other psychiatric disorders and how best to assess these problems. This information may be helpful for identifying effective treatments in the future.

Researchers are looking for people age 18 or older who have (1) problems with excessive clutter or (2) obsessive-compulsive disorder and, (3) live within forty minutes of the greater Hartford or Boston areas. The study consists of a 4-hour diagnostic interview about anxiety and mood symptoms followed by a 4-hour interview about clutter and acquiring. These interviews take place at the clinics.

Additionally, the study will include a 1-hour visit to the participant's home where the participant will take part in an experimental task about removing clutter and another task about acquiring new items. Participants will also have a chance to take part in a discarding and acquisition task. Participants will be paid $20/hr for their time and can make up to $180.

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

New Hoarding Therapy Group

Are you not able to part with anything, including the most useless junk, telling yourself, "I might need it someday?" Does your home resemble a warehouse? Have you pretty much given up hope in obtaining help for your problem?
Are you really motivated to do something about your hoarding? The Hoarding Therapy Group will provide both support and treatment. Individualized treatment plans are tailored to the needs and capabilities of each participant; de-hoarding assignments are manageable. Feelings relevant to the hoarding experience are explored. Guest speakers will be periodically scheduled.
For further information, contact Stacie Lewis, LCSW, at (212) 568-9570 (Manhattan, NYC location).

Please Contribute to the OCF End-of-the-Year Fundraising Campaign

Call for Conference Presentations

The 14th Annual Obsessive Compulsive Foundation Conference is scheduled for July 20 through 22, 2007 at The Woodlands Waterway Marriott Hotel & Convention Center in Woodlands, TX. Anyone interested in putting on a seminar, workshop, presentation or support group must submit his/her presentation proposal to the Conference Committee by January 31, 2007.

Past OCF conferences have offered workshops and presentations on the etiology of OCD, the Genetics of OCD, treatment for symptoms specific OCD, compulsive hoarding, family therapy, treatment-resistant OCD, and new and emerging research. There have been GOAL support groups, workshops for children, adolescents, parents, caregivers, sufferers and mental health professionals.

We invite and encourage clinicians, researchers, sufferers and support givers to submit proposals that will help the Foundation reach its goal of finding "Effective Treatment for Everyone with OCD." Applications for Conference Presentations will be available on-line.

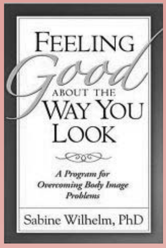
For more information, please contact Jeannette Cole, deputy director, at 203.401.2069 or e-mail her at cole@ocfoundation.org for an application.

SUBMISSION DEADLINE IS FRIDAY JANUARY 31, 2007.

Book Review

FEELING GOOD ABOUT THE WAY YOU LOOK

Author: Sabine Wilhelm, Ph.D.
Reviewer: Bradley Reimann, Ph.D.



Feeling Good About The Way You Look is a self-help treatment manual written for individuals suffering from a wide range of body image-related issues including body dysmorphic disorder (BDD). The author of the book, Dr. Sabine Wilhelm, is the founder and director of the BDD Clinic and Research Unit at Massachusetts General Hospital, and is an Associate Professor of Psychology in the Department of Psychiatry at Harvard Medical School.

The manual is divided into eleven, easy-to-follow chapters, an appendix and a resource section. Chapter one provides detailed case vignettes that help the reader gain an understanding of the wide variety of body image concerns that one could have. In addition, Dr. Wilhelm makes the distinction between perception (one's body image) and reality (one's actual appearance) and states that the gap between these two concepts is where the problem lies. Chapter two provides the reader with an understanding of why s/he may be having body image concerns. Wilhelm reviews media influences, family and cultural contexts, peer influences, personality traits, and brain functioning as all possible factors in the development of body image issues. Chapter three helps readers assess their readiness for treatment and introduces techniques (e.g., cost analysis) to increase motivation to change. Chapter four includes a very thorough self-assessment protocol. Readers are trained to identify appearance-related thoughts, situations avoided because of body image concerns, body image-related rituals that one may perform, and long-term goals an individual has for his/her program. Chapters five through eight provide detailed step-by-step, concrete strategies to overcome appearance related distress. Numerous worksheets, questionnaires, and monitoring forms are provided. Specifically, chapters five and eight address the cognitive or thought piece of body image concerns including the use of Thought Records, and Core Belief Worksheets. Chapters six and seven instruct readers in the application of the behavioral strategy of exposure and ritual prevention. Included in these chapters are Exposure Worksheets, Trigger Situation Worksheets, and Self-Monitoring Forms for Appearance Rituals. Chapter nine provides very helpful tips related to relapse prevention (e.g., Relapse Prevention Planning Worksheet), while chapter ten presents a discussion regarding the potential use of medications to aid in the treatment of body image concerns. Chapter eleven is a review of ways to help a family member or friend with BDD or other related conditions. This chapter includes topics such as "Learning About the Problem," "Being Supportive," "Seeking Emergency Care," and "There is Hope." The manual concludes with an appendix describing BDD's relationship with other disorders (e.g., eating disorders, obsessive-compulsive disorder) and a very detailed listing of resources including treatment clinics, websites, and books Dr. Wilhelm feels would be helpful to readers.

Overall, I believe this is an outstanding resource for anyone dealing with body image related concerns. Dr. Wilhelm provides research supported by step-by-step advice as to how to reduce mild to completely incapacitating body image concerns. The manual is well written and organized. Dr. Wilhelm displays a great ability to explain extremely complex concepts in an easy to understand manner. I believe this one-of-a-kind manual will also prove beneficial to loved ones and therapists not familiar with treating these issues.

Yale OCD Clinic

(continued from page 3)

are currently some of the most effective treatments for OCD. The Yale OCD clinic in the late 1980s and early 1990s was involved in clinical trials evaluating the efficacy of clomipramine (Anafranil), fluvoxamine (Luvox) and fluoxetine (Prozac) in treating OCD. More than 150 individuals participated in at least one of these three trials at the Yale OCD clinic and as part of these clinical trials had a detailed assessment of the history, severity and type of their OCD symptoms. We are currently conducting a follow-up study to determine how these individuals are doing now (approximately two decades after initial treatment), so that we can provide more accurate long-term prognostic information to OCD patients. We are also interested in examining predictors of long-term outcome in OCD based on individuals' original clinical presentation.

Perhaps, most exciting, is that we also have information on how each of these individuals responded to SRI medication from the original SRI clinical trials. Roughly half of OCD patients exhibit a clinical response to treatment with serotonin-reuptake inhibitors. Many individuals considered clinical responders in treatment studies (usually classified by a 25-35% improvement in Y-BOCS score) still exhibit significantly impairing OCD symptoms after pharmacological therapy. Furthermore, adequate medication trials with SRI are lengthy. OCD patients must undergo without success two SRI trials of the maximal tolerated dose for at least 2 months to be considered non-responsive to SRI medication. Most OCD patients non-responsive to SRI undergo at least one year of unsuccessful SRI treatment before trying other augmentation methods for OCD. Although, increased severity and duration of OCD symptoms prior to SRI pharmacotherapy and the presence of OCD symptoms primarily in the hoarding dimension have been associated with poor response to medication, there are currently no reliable clinical predictors for which OCD patients will respond to SRI pharmacotherapy and which will not. As part of the follow-up study we are collecting genetic specimens from the clinical sample.

If you believe that you might be eligible for this long-term follow-up study (participated in past SRI trials in the OCD clinic) feel free to call Dr. Michael Bloch, Phil Dombrowski or Dr. Angeli Landeros at (203) 785-7683.

Compliance with Solicitation Regulations

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

A copy of OCF's most recent financial report is available upon request and may be obtained at no cost by writing to OCF at P.O. Box 9573, New Haven, Connecticut 06535-0573 or by contacting its Executive Director at (203) 401-2074. If you are a resident of one of the following states, you may obtain information directly as follows: **Florida**: A COPY OF THE OFFICIAL REGISTRATION AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE FLORIDA DIVISION OF CONSUMER SERVICES BY CALLING TOLL FREE WITHIN THE STATE (800) 435-7352, OR (850) 488-2221 IF CALLING FROM OUTSIDE FLORIDA. OCF'S REGISTRATION NUMBER IN FLORIDA IS CH8507. **Maryland**: A copy of the documents and information submitted by the OCF pursuant to the Maryland Charitable Solicitations Act are available for the cost of copies and postage from the Secretary of State, State House, Annapolis, MD 21401, Telephone (401) 974-5534. OCF's registration number in Maryland is 5015. **Mississippi**: The official registration and financial information of OCF may be obtained from the Mississippi Secretary of State's office by calling (888) 236-6167. OCF's registration number in Mississippi is C1143. **New Jersey**: INFORMATION FILED WITH THE ATTORNEY GENERAL CONCERNING THIS CHARITABLE SOLICITATION MAY BE OBTAINED FROM THE ATTORNEY GENERAL OF THE STATE OF NEW JERSEY BY CALLING (973) 504-6215. OCF'S REGISTRATION NUMBER IN NEW JERSEY IS CH1461800. **New York: A copy of the most recent annual report filed by OCF with the New York Secretary of State may be obtained by writing to Charities Bureau, 120 Broadway, New York, NY 10271, Telephone (518) 486-9797. OCF's registration number in New York is 66211. North Carolina: A COPY OF THE LICENSE TO SOLICIT CHARITABLE CONTRIBUTIONS AS A CHARITABLE ORGANIZATION OR SPONSOR AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE DEPARTMENT OF HUMAN RESOURCES, SOLICITATION LICENSING BRANCH, BY CALLING (919) 733-4510. OCF'S REGISTRATION NUMBER IN NORTH CAROLINA IS SL002059.** **Pennsylvania**: A copy of the official registration and financial information may be obtained from the Pennsylvania Department of State by calling toll free, within Pennsylvania, (800) 732-0999. OCF's registration number in Pennsylvania is 15687. **Virginia**: A copy of the OCF's most recent financial statement is available upon request from the State Division of Consumer Affairs in the Department of Agriculture and Consumer Services. **Washington**: Additional financial disclosure information may be obtained by contacting the Secretary of State toll free, within Washington, at (800) 332-GIVE. OCF's registration number in Washington is 6363. **West Virginia**: West Virginia residents may obtain a summary of the registration and financial documents from the Secretary of State, State Capitol, Charleston, West Virginia 25305.

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