

MESSAGE FROM THE PRESIDENT

OCF To Move To Boston

Dear Friends of the Foundation,

In my previous newsletter articles, I mentioned that the Obsessive Compulsive Foundation Board of Directors has been involved in a year of Strategic Planning. We have reviewed in detail the mission and the vision of the organization, the current programs and initiatives, the financial solvency of the OCF, the fundraising campaigns, our public service announcements, our connection to the scientific community, our advocacy for the passage of mental health parity legislation and our connection to our Affiliates and Support Groups. The Board has now completed its review and we are committed to continue planning for the future.

I am excited to announce the Obsessive Compulsive Foundation's move to Boston, Massachusetts, in January, 2008. In an attempt to enhance our stature as a national leader in providing information, resources, training, media recognition and a stronger



New home of the OC Foundation

volunteer base, we have decided to position the national office where it will be easier to access global transportation. We will be located in the financial area of Boston near major highways in and out of Boston, within walking distance of the subway system and a short cab ride to Logan Airport and the train station.

The staff for the Foundation will be increased in order to meet OCF's growing role as a resource, an educator and a supporter of increased public awareness and understanding of the disorder. The Board wants to reassure you that the programs and the compassion that has been extended to you in the past will continue in Boston.

Patti Perkins, our current Executive Director, has chosen not to make the move to Boston. We thank Patti for her stewardship of the Foundation as one of its co-founders in 1986 and as a member of the Board of Directors until becoming

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Dr. Jenike Asks for Support for the OCF Research Fund

Dear Friends,

I just finished reading the article by Dr. S.W.



Dr. Michael Jenike

Kim, a member of the OCF Scientific Advisory Board from the Department of Psychiatry at the University of Minnesota Medical School, that he wrote for the Fall OCD Newsletter.

It's entitled "What Might Be Causing OCD Symptoms?" In it, Dr. Kim reviews an article from Nature magazine, which suggests that disabling a certain scaffolding protein leads to OCD-like behavior

in rats while replacing the broken scaffolding protein with a normal protein restores normal behavior.

What's all the fuss about? Well, as Dr. Kim points out, this research gives psychiatry real supportable basic science. According to Dr. Kim, "There is breathtaking progress being made in many fronts in neuroscience, and OCD is one of the areas that neuroscientists have paid close attention to." With this research as a backdrop and with all the work that is being done in the genetics of OCD and in other important areas including imaging, neural circuits, medication therapy and cognitive-behavior therapy, we may be on the cusp of finding real answers to our questions about OCD and the OC Spectrum Disorders.

For example, the members of the OCF

Genetics Collaborative have collected DNA samples on thousands of OCD patients; and we are about to perform a Whole Genome Association Study which will use approximately 2 million genetic markers throughout the entire genome of these thousands of OCD patients to compare the pattern to control

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Bulletin Board

TREATMENT FOR OBSESSIVE COMPULSIVE DISORDER

Important Study Announcement

The Anxiety Disorders Center at Hartford Hospital/Institute of Living is conducting research on new ways to treat obsessive compulsive disorder. Participants in the ongoing studies will receive free cognitive-behavioral therapy, one of the most effective treatments for obsessive compulsive disorder. For more information, please call 860-545-7039 or visit us on the web: www.instituteofliving.org/ADC.

OCD AUGMENTATION STUDY

This study, funded by the National Institute of Mental Health, is a collaboration between Dr. Edna Foa from the University of Pennsylvania and Dr. Blair Simpson from Columbia University, New York State Psychiatric Institute. The purpose of the study is to compare two different, but effective augmentation treatments in order to examine how to maximally improve symptoms of OCD for those who are already taking SSRIs but still have OCD symptoms. Those who participate in the study will continue to take their SSRI and will be randomly assigned to receive one of three different add-on conditions: Cognitive-behavioral therapy (CBT), Risperdal (RIS), or placebo (PBO). Initial treatment will last for 8.5 weeks. Individuals who benefit from the add-on treatment will be invited to continue with the same treatment for six additional months. Individuals who do not benefit from the initial add on treatment (CBT, RIS, or PBO) will be offered 8.5 weeks of treatment with one of the alternative active treatments (RIS or CBT). The add-on treatments will be provided at no cost. Men and women ages 18-70 with OCD who are currently taking SSRI medication are eligible to participate in this study. For further information about this study, contact Jamie York at 215-746-3327 at the Center for the Treatment and Study of Anxiety, or [see our online flyer](#).

NEUROBIOLOGY OF OBSESSIVE-COMPULSIVE SPECTRUM DISORDERS

Dr. Sanjaya Saxena, Director of the UCSD Obsessive-Compulsive Disorders Program, is conducting a research study to identify abnormalities of brain structure and brain function in individuals with Obsessive Compulsive Disorder (OCD) and related disorders, including Body Dysmorphic

Disorder (BDD) and Compulsive Hoarding, and to determine how brain function changes with effective treatment of these disorders. This study is sponsored by the National Institute of Mental Health. Study participants will receive:

- Brain imaging, which is a way of taking pictures of brain structure and function through techniques called positron emission tomography (PET) and Magnetic Resonance Imaging (MRI).
- 12 weeks of free treatment with an FDA-approved medication (no placebos).
- Neuropsychological testing, which includes testing of your attention, memory, thinking, and decision-making, before and after treatment.

To participate, you must either live in or near San Diego, or be able to travel easily to our center for all procedures and treatment appointments. Participants must meet the inclusion criteria for this study. Individuals will be excluded from participation if they:

- Are currently taking medications that affect brain function, such as antidepressants, anti-anxiety drugs, antipsychotics, etc.
- Have bipolar disorder, schizophrenia, post-traumatic stress disorder (PTSD), panic disorder, autism, mental retardation, or an eating disorder.
- Have a neurological disorder, such as epilepsy, Parkinson's disease, stroke, traumatic brain injury, or dementia.
- Have a history of chronic alcohol or substance use.
- Weigh over 280 pounds.

There is NO monetary compensation for this study. If interested, please contact Dr. Jennifer Sumner at 858-534-8056.

OCD SIBLING/TWIN STUDY

Research study at the National Institute of Mental Health

Looking for sibling pairs up to age 65 where one sibling has been diagnosed with Obsessive Compulsive Disorder (OCD) prior to age 18, and looking for identical twin pairs up to age 65 where either one or both twins have been diagnosed with OCD prior to age 18.

This is a brain-imaging study using Magnetic Resonance Imaging (no radiation) in Bethesda, MD. Child Psychiatry Branch, National Institute of Mental Health, National Institutes of Health, Department of Health and Human Services. Travel expenses and accommoda-

tions paid in full.

Please contact: Wendy Sharp, MSW
(301) 496-0851 or (888) 254-3823
sharpw@mail.nih.gov.

BODY IMAGE TREATMENT RESEARCH STUDY

- Do you dislike the way any part(s) of your body (for example, your skin, hair, nose, eyes) look?
- Do you think about your appearance for more than one hour per day?
- Do you worry that your muscles are not big enough, or do you spend a lot of time lifting weights to enhance your muscles?
- Do you engage in any behaviors intended to check on, hide, or fix your appearance (for example, mirror checking, comparing yourself to others, excessive grooming behaviors)?

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OCD NEWSLETTER

The OCD Newsletter is published six times a year.

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The Obsessive Compulsive Foundation (OCF) is 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, the OCF's resources and activities include: an annual membership conference, web site, training programs for mental health professionals, annual research awards, affiliates, and support groups throughout the United States and Canada. The OCF also sends out Info Packets and Referral Lists to people with OCD, and sells books and pamphlets through the OCF bookstore.

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

How To Help The Hoarder In Your Life: Some Suggestions for Family and Friends

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Dr. Renae M. Reinardy

Hoarding is a condition that not only affects the individuals who suffer from it, but also the people who care about them. Family members and friends are often concerned about their loved ones who exhibit this behavior, but find that their attempts to help are often met with resistance and rarely result in long-term change. Family members living with the hoarder experience the hoarding more directly and can be negatively impacted in a number of ways (e.g., not being able to use areas of the house, allergies, safety threats, and psychological stress). I have worked with many families who present for treatment after a disastrous attempt to help clean up their loved one's home. A common situation is where adult children will go into to their parents's cluttered home and clear it out without permission. The most common reactions from the parent who hoards are deep feelings of betrayal, anger, anxiety, and grief. Most family members expect some type of negative reaction, but are often shocked by the intensity of the emotions. It can take several months, or even years for hoarders to recover from a situation like this.

I can appreciate how difficult it is to see your loved one living in a way that you view to be substandard, and in many cases even dangerous. Hoarding is a complicated condition, and it requires a comprehensive plan in order to produce long-term change. There are numerous factors to consider in deciding on the best approach to help your loved one. In this article, I will offer tips on how family and friends can be helpful, briefly describe some components of treatment, and make some suggestions on how to decrease stress in a crisis situation.

WHERE TO START?

First you should educate yourself about this behavior. In the past few years there have been a handful of books written by experts who treat this condition. Go to the Obsessive Compulsive Foundation (OCF) website and look at the Bookstore link for some excellent resources (www.ocfoundation.org). This behavior is so much more

than messiness, and treatment includes much more than just cleaning the house. Hoarding involves both skills deficits that are likely biological in nature, and learning patterns that have been in place for many years, often decades. Many hoarders also have become isolated, distant, and less active. They may replace relationships with connections to their items. Hoarders often find their possessions to be sources of opportunities, reminders of events or people, pleasure, and/or extensions of themselves.

Help your loved one find a professional in your area. In most areas this will be a difficult task. There are not many therapists who specialize in this behavior. You would likely be best served by working with a cognitive-behavioral therapist who is familiar with hoarding or is willing to learn. Again, the OCF Bookstore has great resources for professionals. Supervision and continuing education are also often offered by experts in hoarding.

Be patient. Understand that change is very difficult for most hoarders and therapy is not a "quick fix." The goal of cognitive-behavioral treatment (CBT) is to teach clients the skills that they need to manage problematic behavior on their own.

Reward progress. The change process starts out very slowly in treatment. It may take one hour to go through a half-inch stack of papers. As with any skill, as the person who hoards gets more practice in making decisions regarding his/her items, the process gets easier and things speed up. Remember to give verbal praise to your loved one for *any* effort s/he puts into changing this behavior.

Avoid common traps. Because the process is slow, most family and friends feel pressured to accelerate the process by helping the hoarder make decisions about his/her possessions, or by just doing it for him/her. Since this is a skill, like doing algebra, if you do it for him/her, s/he are not going to learn. When the hoarder does not have an active role in the decluttering process the home almost always becomes reclustered. Also, be mindful of the comments you are making to the hoarder in your life. It is often not motivating to remark on how little s/he is doing, or how long it will take if s/he keeps going at his/her current rate. You will also have to control your excitement to move on to other areas once one area is clear. Pause to notice what s/he has already accom-

plished. These tips make sense to most people, but they can be difficult to actually follow.

Show them kindness. Remember that hoarding is just one component of this individual. Don't forget about all of the things that you enjoy about him/her. I can understand that you may feel cheated by this behavior, but you should know that hoarding is rarely malicious. Most people who hoard find it very difficult to change on their own. Saving their stuff does not mean that they care more about their stuff than you. They are literally unable to do what you have asked of them, which is often to "just throw it out." It is good to rebuild your relationship by doing enjoyable activities together, as strong relationships often make it easier for hoarders to part with their possessions.

WHAT HAPPENS IN TREATMENT?

While therapy should be individualized to meet the client's particular needs, there are common components that are used in successful treatment. Psychoeducation should always be a part of the treatment so that the person who hoards understands that there are millions of Americans who suffer from this condition and that there is treatment available. This often gives people hope, where often there was none.

A behavioral assessment is made to assess the level of clutter in the home, and the thoughts and behaviors that maintain the problem. Compulsive acquisition is also assessed. After the assessment, a behavioral plan is collaboratively made by the client and therapist on how best to start processing the items in the client's home. Target areas are established, and the hoarder begins making decisions about his/her items. Exposure and response prevention strategies are also used to gradually expose a client to difficult decisions, and to help him/her resist the urge to avoid or go back on his/her decisions. Therapists never make decisions for the client and should never touch an item without explicit permission. Clients may bring items into the office, or the therapist may make a home visit at some point during treatment. Simple categorical systems are put into place to help the client develop a systematic way to process his/her items. Churning is strongly discouraged and items should be placed into a final category, rather than just being moved from one place to the next. Clients will

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A RESPONSE TO “..

Jonathan H. Weiss, Ph.D.
New York, NY

The following article was written in response to “This Article Is Rated G (for Guilt)” written by Leslie Shapiro, LICSW, and Ryan Boxill, Ph.D., in the Summer Issue of the OCD Newsletter. We have always wanted the OCD Newsletter to be a market place of ideas from everyone in the OCD community. Feel free to offer a written response to this article or any other that runs in the Newsletter.

I was delighted to read “...G for Guilt” by Leslie Shapiro and Ryan Boxill in the Summer Issue of the OCF Newsletter. For years I have been discussing with colleagues and patients the possibility that OCD, or at least a large subset of OCD, is a disorder of guilt not of anxiety. Like the authors, I came to this idea as a result of extensive experience treating OCD and listening carefully to my patients’ descriptions of their complaints. I noticed early on that, although patients often used the words “anxious” and “afraid” when talking about their symptoms, their concerns were more about unacceptable urges, thoughts and actions that could harm others than about harm coming to themselves. They said things like: “I’m terrified to walk near a window with my baby. What if I throw her out?” “I’m afraid if I don’t put the curtains exactly symmetrical, my son will die in a car crash.” “If I think of my girl friend’s name it could curse her;” and “I worry that I might have left the stove on and the apartment will burn, and it’ll be all my fault.”

All of us who treat OCD have heard variations on these themes. When they did talk about fears of being hurt, my patients often explained that they were afraid they would be punished for their “misdeeds.” For example, a Catholic woman told me that she felt awful about not having taken Communion in years. She explained that she would have to go to Confession first and was frightened about what the priest might say about the “sins” she obsessed about. Also, if I asked them to compare the feelings that accompany thoughts of hurting others and thoughts of being hurt, my patients would usually say that the latter feeling is different or at least not as intense. It seemed likely, therefore, that the primary emotion to which my patients were referring was not anxiety but guilt.

Although most people describe their “bad thoughts” readily, it occasionally takes some questioning before the theme of guilt

becomes obvious. For example, a woman approached me after a talk I had given to her self-help group in Philadelphia and said that, although my ideas were interesting and provocative, she didn’t see how they applied to her. She told me that her obsessions were about her getting AIDS, not about giving it to her family. She went on to describe how she had to walk across the street if she saw anybody who looked dishevelled or homeless or sick. I asked her why, if AIDS can be so easily contracted, she wasn’t afraid of infecting her husband and children. Without hesitating she replied, “But they’re good people. God would never let them be hurt.” Then her eyes widened and she almost blurted out, “Oh my God, I never thought of that. I must be afraid I did something wrong and I’m going to be punished.” On another occasion, a lawyer who hoarded said that he was at a loss to explain why he felt he needed to keep papers that were only tangentially related to cases he had worked on. I asked him what he imagined was the worst that could happen if he threw those papers away. He thought for a moment and said that he imagined a client wanting to reopen an important case and his discovering that what he thought was trivial was actually crucial. “How would that make you feel?” I asked. “Why, irresponsible of course.” Finally, a woman in her fifties whom I had treated for classic symptoms of OCD called, after a long hiatus, to say that she had developed a frightening and debilitating new symptom, viz., a consuming need to know the name and performer of any song she heard on the radio, in the mall or while riding an elevator. Not knowing kept her awake at night enveloped in fear. She had come to the point where avoidance was her only recourse and this was, obviously, costly. She told me that, unlike her previous symptoms, which had to do with hurting other people, this one completely mystified her because she couldn’t see what harm could come to others from her not knowing things about a song. As we spoke, she mentioned, almost as an aside, that not knowing was as frightening as not remembering. She explained that lately she had been finding herself at a loss for a name or a common word and was terrified that this might be a sign of early Alzheimer’s. When I wondered if that fear could have any connection to her anxiety about not knowing, she said that, in fact, a major reason she was terrified of Alzheimer’s was because it triggered pictures in her mind of her aging mother and her children being devastated. At that moment she recognized that, once again,

her fear of harming other people was at work.

Unlike Shapiro and Boxill, the model of OCD that I would like to suggest in outline is not cognitive and does not see conditioning as an etiological factor. It is true, of course, that patients with OCD make distorted assessments of certain risks. Some do believe in the equivalence of at least some thoughts and actions. Some suffer from doubts as if their short-term memory was faulty. And many think in black and white, all or none terms, and make all sorts of logical errors in reaching their conclusions. However, those biases, illogicalities, doubts, and irrational beliefs do not characterize patients’ thinking across the board. And, they often subside when patients have calmed down. For example, a lawyer I was treating told me that he had had a peculiar experience during the previous week. He had signed important documents but was plagued afterward by being unable to remember clearly if he had signed them. He couldn’t shake the doubt and the accompanying concern that his client would suffer because of his negligence. He turned back to the courthouse where the signing had taken place but got there moments after the doors had been locked. He said that as soon as he realized that there was nothing he could do he felt himself grow calm and with that his doubt vanished. Patients also experience moments of calm after doing a ritual, which is why they ritualize. In this it seems to me that Shapiro and Boxill are not correct when they say that rituals do not reduce guilt. They do, but only temporarily, as long as the system that gives rise to guilt continues to malfunction. When patients are calm, their cognitive distortions seem to diminish. Which is why they are able to say, “I know it’s crazy, but...” I believe that, in OCD, emotion gives rise to cognitive distortions, not the other way around. This is not particularly unusual. The literature on decision-making, in everything from behavioral economics to eating behavior, documents how thinking becomes irrational under the press of emotion.

If, as I suggest, (excessive) guilt is fundamental to OCD, where does it come from? Bad thoughts that are taken seriously don’t seem to be the answer. Neither does conditioning, although learning certainly plays a role in OCD: the content of obsessions must be a function of learning history – Jews don’t worry about not going to Mass. Although why one person becomes mainly a checker

. G (FOR GUILT)"

and another becomes a washer remains a mystery. Patients learn to recognize the triggers of their obsessions and how to avoid them. They learn that rituals work and build up habits around them; and obsessional content can generalize along lines of learned associations. Instead, indications that there are genetic predispositions to develop OCD and that acquired physiologic factors, e.g., strep infection, may have an etiologic role, suggest that malfunction in a hard-wired system may be involved. Hints about what such a system might be and how it might malfunction come from the literature on the evolution of adaptations.

We have acquired many adaptive systems that enhance the probability of survival under challenging environmental conditions. The immune system is an example. When it functions properly the immune system detects and helps to neutralize potentially harmful proteins. It does this in two steps. First, the arms of "Y" shaped antibodies recognize targets; and second, the body of the "Y" activates molecules that help to neutralize them. However, the immune system can malfunction in two ways. It can, because of genetic errors or acquired insults such as AIDS or radiation, fail to detect harmful proteins and/or fail to mobilize coping responses to them. It can also, for reasons that are not understood, over-function and give rise to allergies or autoimmune diseases in which harmless antigens or the patient's own body are mistaken as harmful and attacked. (There is a fascinating suggestion, the so-called "hygiene hypothesis," that being in an environment that is too clean can leave the immune system without sufficient experience, so to speak, to differentiate correctly between actual and only ostensible danger.) Other systems such as pain and fear have similar survival value and similar potential malfunctions. The failure of the pain system to send signals (a trivial but familiar example is after dental anesthesia) and mobilize withdrawal can lead to tissue damage and perhaps death. Phantom pain after limb amputation, on the other hand, seems to be an example of the system over-functioning. In the case of fear, excessive risk-taking can happen when the system under-functions, and panic attacks seem to be symptoms of an over-functioning system, signalling danger when there is none.

The growing literature on the evolution of morality and altruism suggests that cooperation, empathy, respect for authority, fairness

and so on have both individual and group survival value. Individuals are less likely to be harmed by other group members if they behave fairly and cooperatively. And a group is more likely to survive a predator's challenge if it is cohesive rather than engaged in internecine warfare. A system that could detect and neutralize impulses to behave in ways destructive to group cohesion would have obvious advantages. Guilt is my suggested candidate for the emotional component in such a system. Thus, a properly functioning guilt system would be on the alert for thoughts, feelings, and impulses that are inimical to group cohesion and, by triggering an aversive emotional reaction, hopefully prevent them from being expressed in action. There also seems to be a third function of guilt, viz., to mobilize behaviors that undo the damage after an infraction has occurred and restore group cohesion. Primates, for example, engage in grooming rituals as a way of setting wrongdoings right. (Grooming, incidentally, is also an index of relatedness.) Humans engage in a variety of mea culpas for the same purpose. Religion and systems of law seem to reflect the working of such a system. Many years ago Freud noted that religion and obsessional neurosis share a common element, viz., guilt.

When the guilt system fails to function, anti-social behavior emerges, often with no accompanying remorse. Thus, the psychopath may be cruel not because he somehow possesses "evil" but because he does not possess the capacity to feel guilty. When, on the other hand, the guilt system over-functions, it goes on high alert and detects harm in fleeting thoughts, impulses, etc., that all people experience but do not react to intensely. It triggers the powerful aversive feeling that demands rituals in order to settle down. It also causes cognitive mischief. I suggest that that is what we call OCD.

Guilt is to OCD as fear is to Panic Disorder. In both, there is hypervigilance in reaction to harmless experiences and powerful emotional (and cognitive) reactions when such experiences are detected. In both, an adaptive system has, through over-functioning, become maladaptive. The goal of treatment, then, is to quiet the system and restore its adaptive status. In OCD, I believe that ERP accomplishes this in several ways. One is by taking control of the over-functioning system and forcing it to work even more until it settles down, much as a racing engine can be quieted by hitting the accelerator. Taking control means

voluntary exposure. I have seen patients expose easily to stimuli that they said terrified them, only to hear them explain that, "You told me to do it, so it's your responsibility if anything happens." The guilt model accommodates this well. It also suggests that reassurance-seeking may be a form of responsibility transfer. A second is by building tolerance to the powerful feelings that are triggered so that rituals can be avoided and the system is interrupted. I call that "emotional weight lifting." Third, ERP is a desensitizing technique that, through repetition, dampens the emotional response to the fantasies that constitute obsessions, much as watching a movie again and again leads to boredom. I often wonder if cognitive interventions affect OCD not directly, but by helping patients to use rational thoughts to stay with ERP until the dampening effect occurs. It is my impression that cognitive restructuring without exposure is not an effective treatment. In addition, I have seen "cognitive restructuring" happen spontaneously when patients are no longer intensely upset. One woman, for example, could not be argued out of her belief that she must have underlying murderous impulses that were controlled only by her OCD fear. I managed to convince her, however, to risk hurting me with a knife. After 15 or 20 minutes of tears and trembling as she held a knife near my chest she let out a great sigh and said, "Of course I always knew that I would never do such a thing."

Does it make a difference clinically whether guilt or anxiety is labeled as the fundamental emotion in OCD? In my experience it does. For one thing, many of my patients report feeling deeply understood when I explain my ideas about guilt. I have heard them say things like: "Yes, that fits me perfectly." "You're right, I've always worried about doing the wrong thing." "I don't worry about myself but I'm always afraid for others;" and "How did you know that about me?" For another, I believe that patients feel normalized and supported when they hear an explanation that makes sense to them and reframes what seems like embarrassing "craziness" or evil intention as, "You're just trying to be as good as is humanly possible." I explain that OCD is opportunistic, attacking their most dearly held values in a mistaken effort to preserve them by stirring up guilt about possible or imagined infractions. Thus, I tell my patients, if the model has any validity, OCD is incompatible with being bad although it is perfectly compatible with feeling bad. I have never, by

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Research Digest

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

For each OCD Newsletter, we review recent articles reporting research on the treatment of OCD. We now have more than 27,000 items in the OC Information Center. An average of 150 new articles on many topics, including basic science related to OCD, arrive each month; but our emphasis remains on treatment as most OCF members interests' understandably lie there. In this review, a recurrent theme emerges full force once again. The first four articles are related to cognitive-behavior therapy (CBT) for OCD, this time for child and adolescent (pediatric) sufferers. Once again, the remarkable efficacy of CBT for OCD shines through. Using the gold standard Child Yale-Brown Obsessive Compulsive Scale (C-YBOCS) as the criterion, four separate studies showed the remarkable value of CBT. With a variety of study designs and methods of providing CBT, including delivery in three regular outpatient clinics by non-academic therapists in one study, CBT produced dramatic improvements.

With baseline C-YBOCS scores of 24.0, 25.7, 23.1 and 32.0 in the four studies, striking improvements of 10.6, 15.7, 15.9 and 20.8 points, respectively, were achieved with CBT. Children in these studies ended treatment with average scores of 13.4, 10.0, 7.2 and 11.2, which are excellent results. Many researchers consider a C-YBOCS score of 10 the cut-off for bothersome OCD. To put these results in perspective, the National Institute of Mental Health sponsored the Pediatric OCD Treatment Study (POTS) which found that CBT reduced C-YBOCS scores 8.3 points while sertraline (Zoloft) decreased C-YBOCS only 3.7 points, after placebo response (3.7) was subtracted from both treatments.

The take-home message: find and use CBT for pediatric OCD. The rub: it's darn hard to find. The OC Foundation is doing all it can to facilitate CBT training for therapists through its Behavior Therapy Institutes. (JHG)

Evaluation of exposure with response-prevention for obsessive compulsive disorder in childhood and adolescence

Journal of Behavior Therapy and Experimental Psychiatry, Epub ahead of print 2007, D. Bolton and S. Perrin

This study provides further evidence that behavior therapy, exposure with ritual prevention (ERP) specifically, is an effective treatment for pediatric OCD. Twenty children and adolescents with OCD, not receiving medica-

tion for OCD, were randomized to ERP or a wait-list control group. The behavior therapy group received up to 10 sessions of ERP alone (no cognitive therapy), conducted between once and three times weekly over a period of up to 7 weeks. There was significant improvement in the behavior therapy group compared with the control group. This improvement was maintained at follow-up, an average of 14 weeks later. Researchers concluded that exposure with ritual prevention therapy works, is not overly complicated, and can be effectively delivered in an intensive format over 4-7 weeks. It does not require extensive time on psychoeducation or cognitive therapy. ERP alone may be especially appropriate for younger children who are not particularly able to describe the content of their thoughts.

Family-based cognitive-behavioral therapy for pediatric obsessive-compulsive disorder: comparison of intensive and weekly approaches

Journal of the American Academy of Child and Adolescent Psychiatry, 46:469-478, 2007, E.A. Storch, G.R. Geffken, L.J. Merlo et al.

Two methods of delivering family-based cognitive-behavioral therapy (CBT) were compared—intensive CBT (14 daily sessions over 3 weeks) and weekly CBT (14 weekly sessions). Forty children and adolescents with OCD were randomized to one of the two treatments. Intensive CBT was as effective as weekly treatment with some advantages present immediately after treatment. Immediately after treatment, 75% of youths in the intensive group and 50% in the weekly group were considered treatment responders. No group differences were found at the 3-month follow-up with approximately 75% of youth in both groups being responders. Both intensive and weekly CBT were similarly effective; however, individual factors may make one preferable over the other. Intensive treatment may be preferable for children with severe OCD, i.e., children not going to school, in an effort to minimize the length or impact of OCD. For children with less severe symptoms, a weekly approach may be preferable to avoid problems of children missing school and parents taking off work, which can be associated with intensive treatment. Also, on the other hand, intensive treatment is an option for families without local access to CBT.

An open clinical trial of cognitive-behaviour therapy in children and adolescents with obsessive-compulsive disorder administered in regular outpatient clinics

Behaviour Research and Therapy, 45:577-589, 2007, R. Valderhaug, B. Larsson, K.G. Gotestam et al.

Research studies have demonstrated the effectiveness of cognitive-behavioral therapy (CBT) in treating childhood OCD. However, the majority of studies have taken place in highly specialized university clinics with above average experience in the treatment of OCD. This study addressed the question of whether CBT would be equally effective in regular clinic settings. At three non-academic outpatient psychiatric clinics in Norway, 28 children (aged 8-17 years) entered this study and 24 (86%) completed treatment and were available for follow-up assessments. Therapy consisted of 12 manual-guided sessions with combined individual and family CBT-based interventions. The program was based on an unpublished manual developed by John Piacentini, Ph.D., and others from the UCLA Anxiety Disorder Clinic, Los Angeles, California. Dr. Piacentini provided training and supervision for the project. Significant improvement was found on all outcome measures after treatment. Manual-guided CBT for childhood OCD can be successfully implemented in non-academic community psychiatric settings with outcomes similar to findings from highly specialized university clinics.

Sequential cognitive-behavioral therapy for children with obsessive-compulsive disorder with an inadequate medication response: a case series of five patients

Depression and Anxiety, 24:375-381, 2007, E.A. Storch, D.M. Bagner, G.R. Geffken et al.

Five children and adolescents with OCD who had an inadequate response to medications received treatment in a 3-week intensive cognitive-behavioral therapy (CBT) program. The severity of symptoms decreased significantly in all cases following CBT. This was an open trial with only 5 patients, but is noteworthy because all children responded and the substantial symptom reductions occurred over a short period of 3 weeks. The intensive program offered the benefit of being able to quickly target problem areas.

g e s t

Family accommodation in pediatric obsessive-compulsive disorder

Journal of Clinical Child and Adolescent Psychology, 36:207-216, 2007, E.A. Storch, G.R. Geffken, L.J. Merlo et al.

Family accommodation refers to participation by family members in OCD rituals—providing objects needed for rituals, giving in to demands to follow certain routines, giving repeated reassurance, or providing extra help with homework or chores. Although well intentioned, family accommodation generally results in greater impairment, increases negative family relationships, and reinforces the child's involvement in OCD-related rituals and avoidance. Most importantly, accommodation counters the goals of behavior therapy, preventing the child from getting the natural habituation of anxiety that results from not doing a ritual and preventing the child from learning that things feared typically do not occur, such as getting sick from touching a contaminated object. This study examined the relationship between family accommodation, OCD symptom severity, parent-rated child impairment, and behavior problems in 57 youths with OCD aged 7 to 17 years old. Parents reported high rates of family accommodation, most frequently by offering their child reassurance and participating in their child's rituals. Family accommodation was related to increased OCD symptom severity, parent reports of child impairment, and child behavior problems. Parents reported that their children became distressed and angry several times per week when accommodation was withheld. In the authors' clinical experience, when families who accommodate their children's increasing demands attempt to stop doing so, the children begin to display increasingly disruptive or anxious behaviors. The high occurrence of behavior problems suggests the need for parent behavior management strategies to be included in the treatment of pediatric OCD.

Risk of adverse behavioral effects with pediatric use of antidepressants

Psychopharmacology, 191:87-96, 2007, W.K. Goodman, T.K. Murphy and E.A. Storch

Authors reviewed evidence that led the U.S. Food and Drug Administration (FDA) to issue a "black box" warning about risk of suicidality (*suicidal thoughts and behavior*) in children and adolescents treated with antidepressants. Possible mechanisms that might account for

this suicidality are discussed, particularly the behavioral "activation syndrome." The FDA analyzed data from antidepressant clinical trials with 4,582 child and adolescent participants. Importantly, there were no completed suicides in any of the studies. The relative risk of suicidality was modestly elevated when all studies were examined. A simplified way to view this elevated risk is that out of 100 children treated with placebo, one might expect 2 children to have some increase in suicidality due to depression itself. Four children treated with antidepressants would experience increased suicidal thoughts or behaviors. While risk with antidepressants is double (4% versus 2%), the risk with either antidepressant or placebo is low. The majority of studies were with depression, but studies also included trials in OCD and other anxiety disorders. Children with OCD and other anxiety disorders also exhibited a higher risk of suicidality. A risk factor for suicidality may be a behavioral "activation syndrome" that includes agitation, insomnia, and irritability. Based on the clinical experience of the authors, signs and symptoms that may signal adverse behavioral effects of antidepressants, particularly selective serotonin reuptake inhibitors (SSRIs), include anxiety, panic attacks, restlessness, hostility, aggression, insomnia, disinhibition, emotional lability, impulsivity, social withdrawal, restlessness, odd behavior, mania, paranoia, or other psychotic symptoms. The early days or weeks of antidepressant treatment correspond to the period of highest risk for suicidality. The FDA intended the boxed warning message (often referred to as a "black box" warning) to remind physicians, patients and significant other people in patients' lives about the importance of monitoring closely for adverse behavioral changes when beginning antidepressant therapy or increasing antidepressant dosage. The boxed warning message has been misunderstood by the media. It does not say that the risk of suicidality from antidepressants is greater than the risk of suicide from untreated depression. The opposite is true—the risk of suicide from untreated depression outweighs the risk of suicidality from antidepressants. The boxed warning says to exercise caution and educate patients and parents about warning signs. Unfortunately, excessive alarm and misunderstanding about the antidepressant-suicidality controversy may deter appropriate medical treatment of not only depression but also other disorders such as OCD.

Response to Rated G (for Guilt)

(continued from page 5)

the way, heard of a psychopath with OCD and would be interested to know if anybody else has. One other clinical benefit of thinking about guilt in OCD is that it sharpens the focus of ERP. I instruct my patients to be sure to be aware of the guilt implications of their obsessions during exposure. For example, I will ask a checker to be aware not only of thinking "I don't know if the door is locked, I didn't hear the click," but also, "Someone will break in and hurt the kids and it'll be all my fault." Or, I will instruct a washer to be aware of thoughts about negligently spreading disease, not just thoughts about being contaminated.

It is possible, as I said earlier, that guilt may play a role in only a subset of patients with OCD. I have had patients referred to me with a presumptive diagnosis of OCD in whom it was my impression that the problem was less guilt than true cognitive distortions. Such patients were not helped much, if at all, by ERP. My unresponsive religious patients, for example, argue with me that their perfectionistic goals are reasonable and that their ideas are correct. The real problem, as they "explain" it, is that nobody else seems to understand the issues as correctly as they do or care about them as deeply. Evidence to the contrary is dismissed with, "Yes, but..." I wonder if OCD is, in fact, the correct diagnosis. The same seems to be true of patients I have seen with hypochondriasis where guilt was not the issue but fear of harm certainly was. Cognitive intervention, e.g., searching for alternative explanations, often helped more than ERP.

The model I have outlined above suggests a number of questions that I would like to mention in closing. First, is it possible that the normal rituals of childhood are a "trial run" of the developing guilt system? Are they tied to a stage of moral development? Second, is it possible, as the hygiene hypothesis suggests, that too little opportunity to experience guilt can throw the system off balance? Could (at least some) patients with deeply religious upbringings be experiencing the effect of excessive guilt avoidance, rather than, as they often believe, the effect of being made to feel too guilty? Would increased exposure to normal guilt have a mitigating effect on OCD? Third, are the typical age of onset and the gender difference in onset related to an emerging sense of responsibility (in our culture)? Fourth, are there different areas of brain activity for anxiety and guilt? If so, does the latter relate to OCD?

Post-Partum OCD: Two Cautionary Tales

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

As much as we would like to think that information and understanding about OCD have improved over the years, the following two stories will indicate that we have much further to go. They



Dr. Fred Penzel

involve a type of OCD commonly referred to as "post-partum OCD." This refers specifically to OCD that is worsened or brought on by the delivery of a baby, and is most likely linked to post-partum depression. I

would actually see this as part of a larger category, where OC symptoms can be touched off or worsened by pregnancy as well. Some adult women who have previously had low-level OCD or even no prior symptoms will suddenly, following delivery, find themselves faced with either strongly increased OC symptoms, or the sudden onset of symptoms where they previously had none.

The form of OCD seen in these post-partum cases is not limited to any particular type. However, there is one form which I have personally witnessed, that seems to cause some fairly serious problems for new mothers. I am referring to what are known as *morbid obsessive thoughts*. These thoughts generally center on the theme that the thinker will deliberately cause harm to him/herself or others. This harm can include violence, sexual abuse, poisoning, murder, mutilation, etc. Why OCD picks up on these particular themes in certain people remains unknown, but it always seems to have an uncanny knack for picking on whatever will bother a person most. Perhaps people obsess about many different subjects, and only those that seem most threatening actually get noticed and then persist.

It should be mentioned here that OCD sufferers never act on morbid thoughts, and are as horrified by and startled at their presence as are some of the people they reveal them to. Those with OCD, in fact, tend to be a lot more risk-avoidant than the average person, and would seem the least likely to ever do anything that would endanger themselves or others. This is all well-known to those who have expertise in diagnosing and treating OCD. For an experienced clinician, hearing people's revelations that they are thinking about doing grievous harm to themselves or

others is generally all in a day's work, and nothing to get terribly excited about. Patients are often relieved and surprised when the clinician isn't shocked or upset, and are relieved when they are informed that such thoughts are common to many OCD sufferers.

Unfortunately, things do not play out this way when a sufferer falls into the hands of someone who is not familiar with the disorder or the different forms it can take. Here are two examples of this type of sad situation.

The first, involves a woman, Sharon,* a 32-year-old fashion designer who had been previously treated by me for problems with obsessive guilt and scrupulosity. She had done well in treatment via a combination of exposure and response prevention and medication, and had reached the point of recovery. At the point when she phoned me, I had not seen her for about a year, during which time she had become pregnant with her first child. She had just given birth to a healthy baby boy in a large Manhattan hospital the day before, and was on the phone in tears. As she related it to me, on her second day after delivering, she began to have intrusive and repetitive thoughts about harming her new infant. These were a type of thought she had not experienced in the past, and even though she had had experience in dealing with OCD, was caught off-guard. Not knowing what to do, she discussed her thoughts with one of the ward nurses. This was where things started to go wrong. The nurse, out of a sense of diligence and protectiveness toward the infant, immediately informed the head nurse, as well as my patient's obstetrician. Apparently, not knowing my patient's history of OCD (which even if they did, probably wouldn't have made any difference), they then took the thoughts at face value and informed her that they would absolutely not allow her to have any contact with her baby in order to protect him from her, and in addition, were ordering an immediate psychiatric consult. Nothing Sharon could tell them seemed to make any difference.

She tearfully called me in a state of panic. "I can't believe what is happening," she said. "I tried to tell them that I would never hurt my baby, but they just wouldn't listen to me. No one believes it when I tell them I would never hurt him. I think these thoughts could be a part of my OCD, but then I get more doubts about whether they are or not. Is there anything you can do?" Sharon couldn't be certain about the nature of her thoughts, because one of the chief hallmarks of OCD is

doubt; and so she even doubted that obvious obsessive thoughts were OC symptoms. One further irony in this whole situation was that the hospital actually had a large OCD treatment and research unit as part of the same complex, but whatever they were learning there had not been communicated to any of its other units.

Fortunately, the story had a happy ending. I was able to phone someone I knew at the hospital's OCD center and asked if one of their more senior people would drop by the obstetrics unit to visit Sharon. They soon did this, and after talking with her, were satisfied that the thoughts were, in fact, just thoughts, and that Sharon had no bad intentions toward her child. They then explained things to the staff there, and the situation was then resolved. I wonder, however, what would have happened had there been no one at this hospital with the knowledge or authority to set things right.

The second story is somewhat less positive. One evening I received a phone call at my office from a distraught young woman I will call Joanne.* She was calling me from a state in the Midwest. What she had to relate was a genuine OC parent's nightmare. Having given birth not long before, she had, as had Sharon, begun to experience thoughts about hurting her new son. "I didn't know why I was having these constant thoughts," she told me. "I would never want to hurt my son, no matter what." Prior to this time, Joanne had never had any symptoms of OCD or any other disorder, and so she had no real idea of what was happening to her. She then did what any concerned parent would do. She got the name of a local psychiatrist (there weren't too many to choose from in her area) and set up an appointment to find out if there was anything she could do about the thoughts. As Joanne related, "The doctor was nice enough at first, but I began to feel that I had made a mistake as soon as I started to tell him about my thoughts. He sat up in his chair and looked at me with his eyes very wide, shaking his head." She went on to say, "He told me that this was a very dangerous situation that could not be ignored, and that he intended to immediately report me to the state's office of child protective services. He went on to say they would take custody of my baby and make sure that nothing happened to him." He wanted to know where my baby was, and who was watching him." At this point, Joanne got up to leave, with the doctor now angrily demanding that she give him the information. She quickly ran to her car in a state of fright

*Her name and the exact facts of the situation have been changed to protect her identity.

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Beyond The Blues: Post-partum OCD

Jonatban Abramowitz, Ph.D., ABPP
University of North Carolina at Chapel Hill

In recent years we have seen an increased focus on mental health during pregnancy and the post-partum period. One reason for this focus is a number of highly publicized cases in which mothers suffering from post-partum depression or psychosis end up actually harming their children. Another important reason for turning attention toward these problems is that we are learning how maternal (mental) health can negatively affect the mother-infant bond and the child's development. When the mother is emotionally unhealthy during pregnancy and the post-partum period, the risks of problems such as low birth weight, attention deficit disorder,



Dr. Jonathan Abramowitz

and soothing difficulties are increased. But whereas post-partum depression and psychosis typically grab the headlines, we are now learning that anxiety disorders, especially obsessive compulsive disorder (OCD), are also experienced

by many new and expecting mothers. Moreover, perinatal (meaning "around the time of childbirth") OCD and other anxiety disorders can also result in the types of adverse consequences mentioned above. When the potential negative effects of post-partum OCD are considered along with the fact that this problem is under-recognized by patients and professionals alike, it is easy to see the importance of learning more about this condition and how it can be managed most effectively. My research group at the Mayo Clinic, and now at the University of North Carolina, has conducted several studies on post-partum OCD, and has treated many individuals with this problem. The goal of this article is to discuss (a) what we currently know about post-partum OCD, (b) what the potential causes are, and (c) what are the effective treatments.

What do we know about post-partum OCD?

Although there are no large studies on the overall incidence of OCD in the post-partum period, we know from several small studies that a greater than expected percentage of women with OCD attribute the onset or worsening of their symptoms to pregnancy or the post-partum period. In fact, among female OCD patients who have

given birth, pregnancy and childbirth are the most commonly cited "triggers" of OCD onset. Still, research suggests that post-partum OCD is fairly rare, probably affecting between 1% and 3% of childbearing women.

In contrast to non-post-partum OCD, the post-partum variant typically comes on rapidly, sometimes within a week of giving birth. Research also indicates that post-partum OCD most often involves scary obsessions related to harm befalling the newborn infant (in contrast to obsessions having to do with contamination, paperwork mistakes, order and symmetry, and hoarding). In some instances, sufferers report obsessions having to do with accidental harm, while in others the obsessions involve unwanted thoughts or ideas of intentionally harming the newborn. Some examples of the kinds of post-partum obsessions encountered in our clinic are as follows:

The idea that the baby could die in her sleep (S.I.D.S)

The thought of dropping the baby from a high place

The thought of putting the baby in the microwave

An image of the baby dead

Thoughts of the baby choking and not being able to save him

Unwanted impulses to shake the baby to see what would happen

Thoughts of yelling at the baby

Thoughts of poking the baby in the soft spot in her head (fontanel)

Thought of stabbing the baby

Thoughts of drowning the baby during a bath

Compulsive rituals among mothers with post-partum OCD often include checking on the baby, for example, during the night to make sure that the baby is still alive. New parents with OCD also report mental compulsions such as praying over and over to prevent disastrous outcomes. Finally, many post-partum OCD sufferers engage in compulsive reassurance-seeking, including looking their symptoms up on the internet and asking others if it's "normal" to have bad thoughts about the baby. Avoidance is also a problem. I have worked with many new mothers who are afraid to be left alone with their newborns for fear that they might act on their unwanted thoughts about harm.

But interestingly, our research indicates that up to 80% of all new mothers (even those *without* clinical OCD symptoms) report nasty, senseless, unacceptable, unwanted thoughts that are similar to those described by mothers with post-partum OCD (see above). Let me say that again: most new parents experience unwanted negative thoughts about their infants – the same kinds of thoughts that mothers with post-partum OCD experience. I'll return to this later because this significant finding has important implications for how we understand post-partum OCD.

What about post-partum psychosis?

Many women suffering from post-partum OCD worry that they might act on their harm-related thoughts, or that their thoughts mean they are unfit to be parents. "What if I drown my children like that woman on the news did?" "What kind of a parent thinks about such terrible things? Surely, I am losing my mind!" What drives these fears is a lack of understanding of the differences between post-partum OCD and post-partum psychosis.

Let me explain. First, both OCD and psychosis can involve strange, bizarre, and violent thoughts. But the similarities stop there. In post-partum OCD, the sufferer is terrified of committing harm; so much so that it scares her to even *think* about harming the infant. Women with post-partum OCD *resist* their obsessional thoughts. They try to dismiss the obsessions, or neutralize them with some other thought or behavior. The thoughts seem as if they are against every moral fiber of their being. Consequently, the risk of someone with post-partum OCD acting on her violent obsessions is extremely low (one can never say with absolute certainty that the chances are 0%; but in this case, it's pretty close).

In contrast, women with post-partum psychosis tend to experience their violent thoughts much differently. The violent thoughts might be perceived as consistent with the person's world view. Hence, such women don't try to fight these thoughts. The thoughts are usually part of *delusions*; that is, lines of thinking in which a new mother holds strongly to bizarre beliefs such as the idea that someone (or the government) is after her, or that she has magical powers that other people don't have. So, thoughts to harm the baby might be perceived as "a good idea." Because people with psychotic disorders sometimes act in accord with their delusions, post-partum psychosis poses very serious risks and often

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Why Should I Participate In OCD Research Trials?

*Krista Vermillion
Johns Hopkins Medical School
Baltimore, MD*

These are exciting times in the field of OCD research. Through research, we are beginning to better understand the causes of OCD and we hope that the future will lead us to advanced treatments for those who suffer from OCD. We are building a solid foundation of knowledge for those who treat patients affected by this disorder, thanks to the participation of sufferers in research. We are also encouraging understanding for those who might not have OCD, but care about someone who does.

That being said, the question still remains: "Why should I participate in a research project?" Hopefully, we can answer that question here.

First of all, in most studies the participation part is actually fairly simple. In the Johns Hopkins OCD Family Study, for instance, we ask our participants to agree to a clinical interview done in person and we also ask permission to obtain a blood sample. Some studies only ask for the interview while others might only ask for a blood sample. Our researchers make themselves available to answer questions and to listen to different concerns of a participant; and, of course, confidentiality of any participant is always assured.

When we asked one participant what it was like to participate in our study, he said this: "One word sums up my experience in the research project – 'easy.' Everyone I dealt with, from the research coordinator to the technician who came to my house was unfailingly polite. I relaxed quickly."

People who go through the process of participating in a research project usually feel very good about themselves when they have completed the study. As the same participant said, "Why not say yes (to participation)? There is everything to win and nothing to lose from devoting several hours to the

study. When someone participates in a study, they are taking steps towards progress."

This leads us to the biggest and best reason to participate in a research study: progress! We are making progress every year. At Johns Hopkins we have identified different regions in the genome that might be involved with OCD, i.e., several different chromosomes that have proven to be interesting in our search for the causes of OCD. Now, we are looking for particular genes that are located in those regions. This will take more time and further lab work on our part. We have also found that a particular form of OCD (hoarding) seems to have a different genetic basis than the other forms of OCD. Furthermore, we have found regions on the genome that may be specific to hoarding and we are following that up as well.

Worldwide, there is great interest in the gene EAACI that was initially identified in linkage studies and has now been found by three out of three research groups to be associated with OCD. This wonderful progress can only be made because individuals with OCD took the time to participate in research projects.

Our advice to those who are considering participation in a research study is to contact the coordinator of the study and find out what participation entails, what the study group is looking for, and what they have found so far. Making a request for more information about a study does not mean that you have to participate, but it does mean that you are taking another step towards finding better treatments for those who suffer from OCD. Research cannot take place without the help of the people affected by OCD.

For more information on the Johns Hopkins OCD Family Study, feel free to contact Krista Vermillion at (410) 923-2918 or visit us on the web at <http://www.hopkinsmedicine.org/ocd>.

The Obsessive Compulsive Foundation 2008 Research Awards Request for Proposals SUBMISSION DEADLINE: FEBRUARY 15, 2008

The Obsessive Compulsive Foundation is committed to finding and promoting "Effective Treatment for Everyone." To further this mission the Foundation is interested in funding research into the brain chemistry, structure and functioning; basic biology; the genetics of OCD; its epidemiology, all aspects of OCD and the OC Spectrum that will lead to prevention and treatment.

The Foundation has been awarding research grants since 1994. Since then, it has funded over \$1 million in OCD Research.

For application guidelines and submission information go to <http://grants.ocfoundation.org>.

MOVING SALE ORDER NOW AND GET 20% OFF BOOKS, PAMPHLETS AND VIDEOS

The Obsessive Compulsive Foundation is moving to Boston in January, 2008, and trying to lighten the load. From now until January 4, 2008, you can buy any books, pamphlets and/or videos advertised in our current Publication List & Order Form for 20% off list price. This means that OCF members will be able to purchase books, etc. at 20% off member price advertised in the Publication List. Non-members will be able to buy this merchandise for 20% off of the non-member price listed in the Pub List. This offer is limited to materials presently in stock.

To purchase anything or for more information, please call Daisy at the OC Foundation 203-401-2070, ext. 13.

Call for Presentations for the The 15th Annual OCF Conference

August 1-3, 2008

Renaissance Waterfront Hotel

Boston, Massachusetts

What is the Annual OCF Conference?

The Annual OCF Conference is the meetingplace where people from all parts of the OCD Community come together to share knowledge, experience and expertise. The OCD Community is composed of people with OCD or an OC Spectrum Disorder, their families and friends and the mental health professionals who treat OCD or are doing research in the field.

Topics of Interest

We have reviewed the evaluation forms from the people who attended our 14th Annual Conference (2007). We have compiled the following list of topic suggestions that may help you to develop your proposal. This list is not exclusive or exhaustive, so please feel free to submit a proposal on any topic that you feel would contribute to our 15th Annual OCF Conference. Please visit the OCF Website for information on how to submit a proposal. Only on-line submissions will be accepted. A partial list of suggested topics include:

- Augmentation strategies
- Reviews of recent treatment modality research
- Cognitive-Behavior Therapy
- Non-traditional treatment modalities
- CBT for specific OCD symptoms
- OC Spectrum Disorders including Trichotillomania, BDD, self-mutilation, cutting, etc.
- Presentations on all relevant topics aimed specifically at adolescents
- Presentations on all relevant topics aimed specifically at children
- Medications for OCD and OC Spectrum Disorders
- Information on treatment modalities for parents
- Coping strategies for family members
- Techniques for getting reluctant sufferers into treatment
- Accessing private insurance, Medicare and Medicaid for coverage possibilities
- Life issues for people over 40, for adolescents, for young adults
- School issues including Special Education
- OCD in the geriatric population
- OCD Genetics research
- Hoarding research, treatment and legal issues
- Impulse Disorders
- In-depth examination of specific OCD symptoms, including scrupulosity, pure obsessions, contamination, hyper-responsibility, tics, 'just right' urges, cleaning, ordering, and their treatment with ERP
- ERP for the sufferer and for support people
- Interactive presentations for children and adults
- Parenting issues for individuals with OCD
- Dealing with adult children with OCD
- Recovery and reentry into life, work, school
- Resistance to treatment
- Relapse prevention
- CBT delivery in non-traditional settings
- Surgery and deep brain stimulation
- OC Personality Disorder
- Co-morbid conditions and their impact on treating OCD

Please visit the Annual OCF Conference website at <http://conferences.ocfoundation.org> for more information.

SUBMISSION DEADLINE: FEBRUARY 15, 2008.

Message From the President

(continued from page 1)

the Executive Director in January 2000. We wish Patti well and look forward to her continued work with the Board as we help those with Obsessive Compulsive Disorder. A thank you is also extended to the New Haven staff, Daisy Sanchez and Jeannette Cole, who have supported the Executive Director and the OCF Board of Directors throughout most of the Foundation's tenure in Connecticut. The Board has retained Nonprofit Professionals Advisory Group to assist in the search for a new Executive Director and other members of the staff.

Today begins the next phase of the Obsessive Compulsive Foundation. We welcome our members to join us as we embark on helping more families and sufferers with OCD. We hope to see everyone at the OCF Annual Conference next summer at the Renaissance Waterfront Hotel in Boston from August 1-3, 2008.

Best Regards,

Joy Kant
President
Obsessive Compulsive Foundation Board of Directors

Research Fund Campaign

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subjects without OCD. We will likely identify many genes that are involved in OCD and then we will be looking for exactly what these genes do. If we can find deficits in protein production of some type or find excesses of some gene product, we can then try to intervene on a molecular level and get at the fundamental problem of OCD. This study should be completed within the next few months, and then it will take a few more months to analyze the data. I think there is a good chance that this will set the stage for much of OCD research for at least the next decade.

Now, with answers on the horizon, is the time to support the Obsessive Compulsive Foundation's Research Fund. This year the Foundation gave eight Research Awards totaling \$290,485.00. According to Patricia Perkins, the Executive Director of the OC Foundation, for the first time in years, however, the Foundation is going to have to dip into

its reserves because we didn't raise enough money in last year's fundraising campaign to underwrite all the awards that were given out.

If you're reading this letter, you are someone with OCD or a person affected by OCD. This group includes family members, friends, treatment providers and researchers. I don't have to tell you how painful OCD is and how it can destroy families, careers and make life very difficult to live.

We have some treatments – medications and cognitive-behavior therapy – that are effective to some extent for some people with OCD. But there are many more for which none of our present treatments are at all helpful. They are trapped in an endless cycle of obsessions and compulsions. They need help and they need it now. We need a total cure for all the people with OCD.

Now is the time to support OCD research, when we are getting answers to many of our questions. We need your support for the research that needs to be done so that we can have "Effective Treatments for Everyone with OCD." Please contribute generously today to our Research Fund. Together we can find the answers.

Sincerely yours,
Michael A. Jenike, MD

Help The Hoarder

(continued from page 3)

save more items in the beginning than what s/he will toward the end of treatment.

Throughout the decluttering process, clients are asked to identify, challenge, and replace thoughts that are contributing to their acquisition, avoidance, and saving difficulties. Treatment should proceed systematically, and goals are adjusted to set the client up for success. The completion of weekly homework is an essential component of successful treatment. As hoarders progress through treatment, they are able to learn the skills to change thinking and behavioral patterns. This will result in long term changes that help them maintain their decluttered living environment. Relapse prevention is discussed with clients, and they may need occasional booster sessions to maintain their gains long term.

Special Considerations

There can be factors that prohibit the therapeutic process from proceeding in the way that I just briefly described. When hoarders are living in truly dangerous conditions (e.g., home structural problems, extreme fire hazard, mold, animal waste), are involved in legal issues, dealing with

social service agencies (e.g., child protective services), have a deadline to move out of their home (e.g., eviction, move to assisted living, sale of home), or are physically unable, then other means may be necessary. In these situations family members, friends, hired help or even legal authorities may become involved in the disposal of items. It is important to understand how incredibly stressful this can be for the individual who hoards. It is also important to understand that the hoarder will often harbor strong negative feelings toward the individual(s) involved in the process.

One way to diminish the negative effects of this situation is to work with a therapist in a "crisis management" type of way. In most situations the hoarder should be aware of what needs to happen and how it is going to occur. S/he should be given the opportunity to work with someone to decide on necessities that need to be removed from the home. Of course, the individual will not be able to save as much as s/he wishes, but there can be truly important items that s/he wants to retrieve that others may not know about (e.g., a picture of his/her mother, diary, special jewelry item, hidden cash, or a favorite shirt). When the hoarder is able to retrieve a few of these items, it can make an

extremely difficult situation a bit easier.

Once the home is decluttered, you need to understand the hoarding problem is not solved. If the hoarder does not learn the skills that s/he needs, re cluttering his/her old environment or new one is highly likely. In treatment, a therapist can help the individual process the event, mend relationships, and learn the skills to overcome his/her hoarding so that s/he will likely never have to go through that situation again.

There is much more information now available on hoarding; but additional work needs to be done to improve the availability of treatment and its efficacy. Resources are also lacking for providing services to family members and social service organizations to deal with hoarding. While hoarding can be a difficult condition to treat, it is often treatable. Some of my most devoted, funny, intelligent and caring clients have suffered from this condition.

Resources

The OC Foundation has several articles available to read on its web site and has books available for purchase. I would also encourage you to visit the Children of Hoarders website at www.childrenofhoarders.com.

Beyond the Blues

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requires hospitalization to ensure the safety of the mother and the infant.

Post-partum OCD in fathers?

My colleagues and I have found in a number of studies that new *fathers* are also vulnerable to OCD symptoms. First, over two-thirds of the healthy new fathers we studied reported unwanted, scary, negative thoughts about their newborn just like mothers did. Furthermore, we have seen a number of new dads with clinically severe OCD symptoms that reportedly started soon after the baby was born. So, post-partum OCD does not appear to be only for new mothers! Why might fathers get “post-partum” OCD symptoms? My colleagues and I have developed a theory, which I describe below.

What causes post-partum OCD?

Two main explanations for post-partum OCD have been described in the research literature. I will review them only briefly here since neither is definitive. First, let's consider the biological model. Because pregnancy and the post-partum period are biological events that involve fluctuations in hormones, some experts believe it is these hormonal fluctuations that give rise to post-partum OCD. In particular, levels of progesterone and oxytocin—two hormones that are involved in the termination of pregnancy—are in flux during this time period. Research has linked oxytocin, in particular, with serotonin, a neurotransmitter believed to play a role in OCD. Thus, it is thought that imbalances of oxytocin can change levels of serotonin in post-partum mothers, possibly leading to OCD.

While the biological model is interesting, it remains speculative since it has not been well tested. One difficulty I have with this model is that it doesn't explain why the obsessions in post-partum OCD tend to revolve around harm coming to the newborn baby, as opposed to concerning contamination, order, hoarding, or other common symptom themes in OCD. It also does not explain why almost all new mothers have unwanted infant-related thoughts, but only some develop clinical levels of OCD. But my most serious criticism of the biological approach to post-partum OCD is that it cannot explain how post-partum OCD can occur in new *fathers* (who do not experience the same hormonal fluctuation as do childbearing women). For these reasons, I believe we need to look beyond purely biological explanations for post-partum OCD.

My colleague, Dr. Nichole Fairbrother, and I have recently developed a psychological model of post-partum OCD. It begins with our finding that most new parents (mothers and fathers) experience unwanted infant-related thoughts (perhaps such thoughts have evolutionary significance). That is, we consider such thoughts as a completely normal and harmless part of early parenthood. The trouble begins, however, when a new parent mistakenly *misinterprets* these normal thoughts as indicating something very significant and threatening. For example, a new mother misinterprets her violent thoughts as meaning that she is likely to kill her baby, or a new father interprets his images of the baby dying as meaning that deep down he *wants* the baby to die. Why might someone misinterpret intrusive senseless thoughts as very significant? We think it has to do with the rapid increase in responsibility—which certainly is the case when one becomes a parent and gains the responsibility of caring for a helpless infant.

When normally occurring post-partum thoughts are misconstrued as dangerous or very significant, it leads the person with such thoughts to become anxious and fearful. Moreover, it leads to behaviors such as avoidance of the baby, reassurance seeking, and excessive ritualistic checking or praying. All of these behaviors are consistent with feeling threatened by upsetting thoughts about one's child. Because these avoidance and ritualistic strategies seem to work (that is, no harm is committed), the new parent keeps on believing that the strategies have prevented catastrophe (when in fact, the thoughts are meaningless). Therefore, the strategy becomes a compulsive behavior, and the fear of acting on the unwanted obsessional thought remains intact (it is never disproved). Furthermore, when the new mother or father keeps their negative thoughts to him/herself (“They would put me in the hospital if I told them about the thoughts I was having”), it further prevents them from learning that such thoughts are normal occurrences (others have them too).

Treatment of post-partum OCD

As with OCD that occurs outside of the perinatal period, post-partum OCD responds to medications using serotonin reuptake inhibitors, and to cognitive-behavioral therapy (CBT). Serotonin reuptake inhibitors are effective treatments for OCD, yet their risks to the unborn and breast-feeding child are not well known. Many experts believe that these medicines are probably not dangerous, but it is important to discuss the possible risks with one's doctor on an individual basis.

A safer, yet more challenging treatment approach is CBT. Demonstrated to be more effective than medications for non-post-partum OCD, CBT for post-partum OCD symptoms involves four components. The first component is assessment, in which the therapist learns about the specifics of the obsessional thoughts, interpretations of the thoughts, situations that trigger the thoughts, and how the person responds to the obsessions (avoidance, compulsive behavior). The second component involves education about the normalcy of negative thoughts around the time of childbirth. That is, we teach the patient about how virtually everyone has such thoughts, but the problem is in how the thoughts are misinterpreted in ways that bring on anxiety. The third treatment component is cognitive therapy, in which specific misinterpretations of intrusive thoughts are identified and challenged. For example, the patient is helped to look at evidence for and against her or his ideas that violent thoughts will lead to acting violently against one's will. Finally, the fourth component of CBT is exposure and response prevention (ERP). During ERP, the patient is helped to confront situations and thoughts that evoke distress, while simultaneously refraining from compulsive behaviors. For example, a new mother with fears of bathing her newborn son because of obsessional thoughts of drowning would practice giving the baby a bath to find out that she is not likely to commit any harm. ERP takes the wind out of the sails of obsessional fears because it allows the person to see that what they were afraid of is much less likely than had been thought.

Some final thoughts

Let me end with some final words for people who might be suffering silently with post-partum OCD or obsessions. First, if you are *afraid* of your thoughts, or so fearful of acting on post-partum obsessions that you are avoiding situations (or trying to avoid certain thoughts), the chances are very good that you have post-partum OCD and *not* psychosis. Therefore, your risk of acting violently is extremely low. Second, it is important to tell someone about your obsessional thoughts so that you can get help. Bring this article to your physician or mental health professional and explain what you are experiencing so that you can get help. Finally, having a new baby should be a happy time of life (although it is stressful, too). Effective treatments for post-partum OCD and anxiety are available, and you (and your newborn) deserve to have the opportunity to receive the benefits of effective interventions. Don't be afraid to speak up and ask for help.

Fun, Fitness and Funds

Elaine Davis, Ph.D.

Vice President

OC Foundation of Western Pennsylvania

Saturday, November 3, 2007 dawned a bit cooler in the northern suburbs of Pittsburgh than in the weeks preceding it. It was hard to believe that a mere two weeks prior, the temperatures were close to 70. Today it was 31 with our first heavy frost – a bit chilly for the set up and volunteer crews for the first Dirt Monster Five Mile Trail Race. But it was considered near perfect weather for the runners. We went into the day with 67 pre-registered runners. Those numbers swelled to 98 with additional people signing up that morning.

Maybe I should back up. The Obsessive Compulsive Foundation of Western Pennsylvania, an affiliate of the OCF, had struggled to find the “right” fundraising event. We had tried dinners, a beer tasting, gift wrapping programs, carwashes, etc., to supplement our treasury. None seemed to be the right fit. We were either tapping into the same pool of donors (our members) or netting very little money for the effort expended. We needed something that would attract people outside of the OCD community. We decided on a race. Runners will show up regardless of the cause. We hoped that we would also bring out some of our core OCF community as well. As an added benefit, the race registration forms were distributed in various businesses around town. Each one had a little blurb on OCD so we could do some

community education at the same time. We also planned to print t-shirts. This would mean that after the race, the participants would walk or run around with our logo on their backs.

So, a little over a year ago, we started the process. Seeing that the racing schedule was full of

5K runs and other races on pavement, we decided to go for a five mile race on all dirt trails. We wanted to stand out and offer something different. Next we found a local running store that was willing to back us. This was a key point. They have a presence in the running community, so they could promote the race and give us feedback about the “buzz” around the race. Running Wild provided this service willingly once they saw that this was going to be a different type of race. They also promised to provide prizes for the event. We were off.

We chose North Park, a large county park. This park was not only close to the race director and Running Wild; it is also a park with large sections of trails. We went out and measured potential race courses. If we could find a course that would loop around to finish at the same point as the start and not cross any paved roads we could save some money. Professional race timers charge extra when they have to set



Even these young girls felt the cold

up in two locations. Crossing pavement would also mean that we would have to hire police to direct traffic. These were both major expenses that we hoped could be avoided.

With the details mapped out, we had to convince the Allegheny County Parks Department that this race was worth holding. North Park already hosts the majority of “measured” events happening in the county parks. Unfortunately, all these events are held on the five mile paved trail around the lake. We were treading on new ground. For anyone who has ever dealt with large government agencies, they prefer to go with the tried and true. No one had expected this to be a stumbling block. It was interesting that we

had to convince the park administrator that there were indeed five miles of trail in the park which met our needs. After walking her around the course and explaining that it was more difficult to find a course that was “only five miles” than it was to find a “full five miles,” she was convinced. Far later than anyone had anticipated, we had approval.

At this point, it was August. It was a good thing that we had been planning this for some time. While we had expected it would take months to secure sponsors, hire a timing service, get additional prizes donated, advertise, set up registration, plan the post race refreshments and secure a shirt design, we now had only eleven weeks to do everything necessary. It was a massive effort, but we all pitched in and remained committed. Board members and professional members approached every business they knew to solicit sponsors.

Race registration brochures were printed and distributed. We worked the details out with the timer. An artist agreed to do the artwork for our shirt for a bargain basement price. We also found someone willing to produce the shirts at a “bulk printing” cost regardless of how many we printed. We began to get the race listed on various web sites that runners use to find the race schedules. It got a bit scary as money was flying out and we had run through all the sponsorship money. We had to cross our fingers that the racing community would embrace the concept.

As the deadline to “guarantee a shirt” with a paid registration approached, so did the number of registration forms arriving in the mail. We began to edge up from “breaking even” to maybe actually making money. The Excel spreadsheet became a daily gauge for how many more participants we needed. Soon we began to breathe a little easier. Excitement soon followed.

The state regional cross country championship occurred one week before our race. As only three teams from Western Pennsylvania make the state finals, there were some school athletes out there looking to extend their season. They hadn’t signed up earlier because they all were hoping that they would secure a spot in



A Race to the Finish

the state meet. High school coaches also suddenly found themselves free. They discovered our race. A few last minute sponsors also gave us some additional money.

Then we had that beautiful cold, sunny morning. Several volunteers were directed to various points in the woods on the course to direct the participants along the way. The registration volunteers were blowing on their hands and trying to get pens to work in the sub-freezing weather. It was important. We had 31 new people trying to register prior to the start of the race. We only had an hour to process them as well as handling the packet pickup for the pre-registered people. The extra



1st Woman Finisher

shirts we had printed went fast. We were able to handle all the administrative tasks and get everyone to the starting line fairly close to the advertised start time. Finally the gun went off. The runners and walkers started on their way. It was a challenging course. They went uphill for the first mile. After getting to the top of the hill, they were treated to a mile back down the other side. Mile three was interesting as it not only climbed back up to the ridge, it did so on a narrow path where passing was not easy and tree roots threatened to cause stumbling. At least the walkers were allowed to skip this trail. At the top of the hill, water was provided. The next 1.5 miles finally allowed the runners and walkers to stretch their legs. This part of the course was fairly flat, circling around the ridge of the hill. But remember, the race started at the bottom of the hill so they did have a steep trail back down to the finish line for the final half mile.

Tim Snyder was the first runner to complete the race in 33:05. Ray Worrell and Dominick Wyzomirski followed 25 seconds later. Sandi Fisher won the woman's overall race in a time of 41:57. Thirteen-year-old Taylor Mozurak took second place, while Edna Spang rounded out the top three for the ladies. Age group winners included

Ryan Papariello and Taylor Mozurak in the under 18 category. Tim Snyder and Courtney DiVito

came in first and second in the 18 to 34 group. Dominic Wyzomirski and Sandi Fisher took the ages 35 to 49 category, while John Edleman and Deb Cully were first in the 50 and over age group. Our first OCD treatment provider to cross the line was Dr. Andy Gilbert. A large number of OCF members were joined by family and friends for a walk or run in the woods. It appeared that everyone had a good time.

Thank you to all the race committee, the dedicated volunteers, our sponsors and everyone who participated in the race itself. Special thanks to the entire staff of the WPIC Adult OCD-IOP for giving up their Saturday to direct people on trail. Other professional members provided additional essential help. We also want to

recognize the efforts of one dedicated member who always steps up to volunteer for any OCF activity. You know



Dr. Gilbert Crosses the Line

who you are.

We are chalking this one up as a success. While the exact amount will be determined after paying our final bills, the race profit was over \$1,200.00. We held such a quality event that we have been asked to repeat it by the running community. We got our name out there. We learned quite a bit in the planning and execution of the race. Hopefully, we will be able to make improvements for next year's race. If you are interested in holding a race in your area to benefit the OCF or one of its affiliates, free to contact me at ocdirections@verizon.net to get some tips on how to get your event off the ground.



Smiles from our "runner volunteers"

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We are offering our program to educate the educators to anyone who will put on a presentation for teachers and other school personnel for only the cost of postage and handling, which is \$10.50.

This multimedia program includes two videos, a "Presenter's Manual," which contains a tightly written script, and transparencies. It also contains "School Personnel: A Critical Link in the Identification, Assessment and Treatment of OCD for Children and Adolescents" by Gail Adams, Ed.D., and the pamphlet "Obsessive Compulsive Disorder in Children and Adolescents," by Hugh F. Johnston, M.D. and J. Jay Fruehling, M.A.

To order your kit, call 203-401-2070, ext. 13. There are a limited number available. This offer is only for the kits we have on hand now.

One Mother's Journey

*Laurie McDonagh, RN
Vice President, OCF Jacksonville
Jacksonville, FL*

A few weeks ago the OCD Newsletter arrived, and as usual I enjoyed reading the many wonderful articles. As a mother of a twenty-year-old son with severe OCD, I am always heartened by articles from parents of children whose OCD has gone into remission. It helps my personal perspective to read about the success of others that my own family has not experienced.

I would not be honest if I did not write of the sadness and sense of loss that resonate within me for my family and those like us who have not seen our children improve but whose experiences, are, never the less, just as valid.

My son says OCD has always been with him as far back as he can remember, even when he could not express the fears to us. Initially, OCD made its appearance masquerading as separation anxiety, later as school phobias and panic attacks. Finally, when he was ten years old, it manifested itself in the classic hand-washing presentation. He was besieged by fears of germs and contamination and was washing his hands until they bled, using barriers to touch things, and avoiding the children at school. Although he had been seeing a child psychiatrist for anxiety, OCD had not been a working diagnosis. I remembered seeing these behaviors during my psychiatric training in nursing school and insisted that he be evaluated for OCD.

Thus, began our long day's journey into night, through many medications, doctors, therapy and depression. There was a duality that encompassed our lives. To the world we appeared as a normal family with three active boys, but within the walls of our home we struggled with our own private hell, unable to make sense of the rapidly unfolding dysfunctionality.

I found the OC Foundation and ordered every book and tape that pertained to kids. I was convinced that if I learned enough, worked hard, and found the right medications, and the best doctors, together we would overcome this thing that had stolen life as we knew it. I quit my part-time nursing job to focus more time on my son's evolving school problems. I became his advocate at school since no one there had ever heard of OCD. During this time I became active in our fledgling local OCF Affiliate. In 2001, with the

help of another mother, I began the MOCCA (Mothers of Obsessive Compulsive Children and Adolescents) support group for parents.

During this time, however, my son was not improving. His OCD waxed and waned regardless of the measures taken. His obsessions dominated most of his thoughts. He had difficulty completing school assignments, taking written tests, and reading novels. We hired a tutor for math, and soon she was tutoring him in most subjects. His obsessions dominated most of his thoughts. Luckily, he was attending a small private school for middle and high schoolers, and they were incredibly understanding.

My son's OCD became very severe during his junior year. My husband and I had frequent discussions about hospitalizing him. We were living a nightmare. His high anxiety levels gave way to terrible frustration and then to angry outbursts. We were eventually able to convince him to enter outpatient intensive therapy. We rented an apartment, and our son and I temporarily moved to another state.

We had high hopes for therapeutic success, but once again he made minimal progress. Each evening he would come home and carry out hours of washing compulsions that he had worked so hard to control during the day. It became apparent that at this pace, improvement would take a great deal more therapy. Unfortunately, more time away from school was endangering his graduation, and he wanted very much to graduate with his friends. We returned home; and after graduation, I contacted two residential OCD treatment centers and he was placed on their waiting lists. During this time our family life was unbearable. We were averaging three to four hours of sleep at night, and my husband and I were both working full time. Most of the nighttime hours, I was trying to convince our son to go to bed. He was at the bedside or stalking me throughout the house, seeking reassurance. My unwillingness to help him complete rituals or reassure him would throw him into angry rages.

Finally, after three months my son was admitted to one of the treatment centers. His dad and I were terrified this too would be unsuccessful. One month after entering treatment he was recommended for discharge. Although I still cannot completely understand why, he was either unable or unwilling to push beyond a certain point in his behavior therapy. Since he was still on the waiting list for another

facility, we sent him there a few weeks later. Once again, one month after admission, he was recommended for discharge for the same reason.

My son has been home for a few months. He has been able to put some small limits on his rituals after residential treatment; and most important, the intermittent rages seem to have abated. But he is far from healthy, and his life is narrowly constricted by his OCD. He is working towards independent living, getting a driver's license, and a part-time job with computers. Change for him is very difficult, and he would rather stay at home. He has moments of great courage when he challenges himself, but it is heartbreaking to witness that he can never relax and enjoy life.

The ravages of severe OCD in children are profound. Like a thief in the night, it steals childhood and leaves in its wake stunted emotional maturity, as it tears at the very fabric of the family. OCD is a demanding taskmaster that will be satisfied with nothing less than all the time and energy parents have to give. Often even that is not enough, and families are broken under the strain.

The painful truth is that sometimes, despite excellent professional care and dedicated parenting, your child just does not get well. Sometimes this is as good as it gets, for now. It is a hard reality, but just as you did not cause the OCD, you cannot control it. And no matter how hard you try, you cannot cure it. Personally, this has been knowledge painfully gained. I have spent ten years fighting this reality. At some point my son must claim ownership of his disorder. Ultimately, he is alone with his illness; and only he can confront it. As much as I would like to take that burden from him, I cannot.

I don't know what the future holds for my son, but I now understand my job is to move him toward independence and then to step aside and let him take up his own battle with OCD. He has been given the tools with which to fight, and now he must find the will to do so.

In closing, I would like to emphasize the necessity of finding support for yourselves, whether it be in the form of a support group or a trusted friend. They will help you take each day at a time and boost your spirits when life feels hopeless. Support systems provide a much needed perspective to focus on the incremental gains your child makes and the effort expended to make those gains. When you are living in the eye of this storm, every day can be a struggle. Parents, be kind to yourselves; stay strong; and never, never lose hope!

Post-partum OCD

(continued from page 8)

and bewilderment, and went straight home. Once there, she hastily packed a bag, grabbed her infant son, and drove to the home of relatives in a neighboring state. While at their home, she had gone on the internet and done a bit of research about people who had thoughts of harming their children, and come across an article I had posted there, concerning morbid thoughts. She saw herself in this article, and had decided to call me.

There wasn't much I could do about the situation in her home state at that point, as she had already decided to relocate to the state she was presently in. I was able to tell her more about her post-partum OCD and about morbid thoughts in general. I was also able to give her the name of a psychologist in her new location that had a lot of experience in the treatment of OCD, who I believed would be able to help her. After I got off the phone, I wondered how many other new mothers had found themselves in such a predicament.

What bothers me the most about both of these stories is that they each involved professionals who were responsible for the well-being of others, but who lacked crucial information about OCD and were completely unequipped to recognize or deal with it. One was even a mental health professional who really should have known better. Rather than try to fix the blame on anyone or any institution in particular (although there is plenty of blame to go around), I think that the point of all this is that it highlights how much more work needs to be done in terms of getting the word out on OCD to the public and health professionals alike. In Sharon's case, if she had simply begun to show signs of severe depression after giving birth, the hospital staff would most likely have recognized what was happening and would have treated her with understanding. The same would probably have been true in Joanne's case.

I think that those of us who treat OCD need to continue to teach the public, the school systems, and other professionals in any way possible through web sites, publications, lectures, media appearances, etc. I also think that those of you out there who suffer with OCD and the members of your families need to put your support behind the OCD Foundation in its quest to educate society about this serious and often puzzling disorder. It really isn't all that hard to diagnose; and once diagnosed, there is much that can be done to help sufferers to recover.

MRSA is Coming! Should I Be Obsessing?

*James Claiborn, Ph.D., ABPP
South Portland, ME*

MRSA is an abbreviation for a bacteria from the staphylococcus (staph) family that has become resistant to treatment with antibiotics. It is the subject of frightening stories on the TV news and a focus of obsessive worry. In this article, I will explain MRSA and suggest how people who are obsessed with it can best deal with their concerns.

MRSA is the product of evolution in the world of antibiotics. Bacteria tend to reproduce rapidly, and those that survive adverse conditions pass on their advantages to the next generation. If a person is treated for an infection with an antibiotic some of the bacteria are likely to survive. Those that successfully survive in the presence of an antibiotic pass on the ability that leads to the development of increasingly resistant bacteria. Eventually, we get super germs. This process is sped up by excess use of antibiotics and ironically means that hospitals are more likely to have MRSA and similar resistant bacteria than other locations.

Staph bacteria are found in about one-third of the population. Those who carry the bacteria but are not sick are said to be colonized. Staph are found commonly on the skin and in the nasal passages and only cause a problem when they get in places like cuts in the skin. Most staph infections are minor and can be treated with out difficulty. Because MRSA is by definition resistant to antibiotics, it is somewhat more difficult to treat. People most at risk are those with compromised immune systems, and chronic illness.

What does this mean for health professionals and everyone else? What are we supposed to do? There are standard procedures and precautions that people working in hospitals and other health care settings are expected

to follow. These standard precautions include things like using gloves and washing hands or using sanitizers according to a set of rules. The rules are designed to reduce the risk of harm to both patients and staff. While actual practice is likely to be somewhat short of the standards in health care settings, the standard precautions are reasonable, and staff are expected to understand and follow them.

The advice for those of us functioning out in the real world is very different. Some recent TV stories about MRSA led to some people with OCD to begin to obsess about getting MRSA. People with OCD want to know what rules to follow and how to be sure they are safe. As with any other obsessive concern they are prone to developing their own set of special rules or rituals to make sure they are safe. Ironically the most common strategy is actually likely to increase risk. Excess hand washing leads to skin breakdown, and the cracked skin opens a path for bacterial infection. So what is a person supposed to do? The best answer may sound harsh, but it is to do nothing. Take no special precautions.

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for the
End-of-the-Year
Campaign**

Bulletin Board

(continued from page 2)

- Do you avoid any places, people or activities because of your appearance concerns (for example, do you avoid bright lights, mirrors, dating, or parties)?
- Do your appearance-related thoughts or behaviors cause you a lot of anxiety, sadness, or shame?
- Do you have problems with your work, school, family, or friends because of your appearance concerns?

If you answered any of these questions with "yes," you might be eligible to participate in a study at Massachusetts General Hospital (MGH). If you qualify, you will receive the following:

Diagnostic Evaluation at no cost

Medication Treatment at no cost

You will also be asked to fill out some questionnaires assessing body image symptoms, anxiety and mood. The treatment will be at no cost for you.

If you are interested in participating or would like to get further information, please call Stephanie Renard at (617) 643-3079 at Massachusetts General Hospital (MGH), Body Dysmorphic Disorder Clinic, or send an email to bbd@partners.org.

OBSESSIVE COMPULSIVE DISORDER STUDY FOR CHILDREN AND ADOLESCENTS

If your child or teen (ages 7-17) is suffering from Obsessive Compulsive Disorder (OCD), he or she may be able to participate in a research study at the National Institute of Mental Health (NIMH). We are investigating the medication riluzole.

Children and adolescents with a primary diagnosis of OCD, or both Autism Spectrum Disorder and OCD may be eligible.

Participants will be randomized to either riluzole or placebo (pill with no active ingredient) for 12 weeks. At the end of 12 weeks, all participants will have the option of taking riluzole (no chance of placebo). A comprehensive psychiatric and medical evaluation and follow-up visits approximately monthly for 6 months, and at 9 and 12 months, are included. There is no cost to participate; travel assistance may be provided.

For further information, please call 301-435-6652 or 301-496-5323 (Lorraine Lougee, LCSW-C) or email OCDNIMH@intra.nimh.nih.gov.
National Institute of Mental Health,

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

RESEARCH VOLUNTEERS NEEDED!

Have you been diagnosed with Obsessive-Compulsive Disorder?

Do you experience symptoms such as persistent, unwelcome thoughts or images, or the urgent need to engage in certain rituals like repetitive hand washing, counting, checking, or cleaning even though you have been treated with medications?

If so, you might qualify to participate in a research study!!

To be eligible, you must also:

- Be at least 19 years old
- Be willing and able to come to the clinic weekly for 14 weeks

We offer:

\$25 per visit for time and travel, physical examination, EKG, laboratory work-up, and study medication at no cost to you. If you are interested in participating in this research study, please call the Psychiatry Research Center at 402-660-2903 or Angie at 402-345-8828 x 24
Creighton University
Department of Psychiatry
3528 Dodge Street
Omaha, NE 68131

ACAMPROSATE (CAMPRAL) FOR SSRI RESISTANT OBSESSIVE COMPULSIVE DISORDER

Principal Investigator: Sriram Ramaswamy, MD
Creighton University
Department of Psychiatry
3528 Dodge Street
Omaha, NE 68131

The selective serotonin reuptake inhibitors (SSRIs) are usually the first line of treatment for Obsessive Compulsive Disorder. However, treatment resistance to SSRIs (Prozac, Zoloft, Paxil, Celexa, and Lexapro) is quite common and a major clinical problem. Our aim is to study the efficacy and safety of adjunctive acamprosate (Campral) in SSRI-resistant OCD. Acamprosate (Campral) is approved by the FDA, but not for the treatment of OCD. The study will involve weekly visits for 12 weeks and participants will get free medical care, study drug and a \$25 stipend for each completed visit.

If you are interested in participating in the study, or finding out more about it, please call the Creighton Psychiatry Research Center at 402-660-2903 or visit our posting on careerlink.com.

DOES YOUR CHILD NEED TO DO THINGS OVER AND OVER AGAIN? DOES

HE OR SHE HAVE RECURRENT AND BOTHERSOME THOUGHTS OR IMAGES?

Does your child repeatedly check or arrange things, have to wash his/her hands repeatedly, or maintain a particular order? Do unpleasant thoughts repeatedly enter your child's mind such as concerns with germs or dirt or needing to arrange things just so?

If this sounds familiar, your child may have a treatable problem called Obsessive Compulsive Disorder (OCD). Past research has found that a form of cognitive therapy, called Exposure and Response Prevention Therapy, is helpful in as many as 85% of children with OCD. We are interested in determining if adding a medication called D-Cycloserine improves the effectiveness of Exposure and Response Prevention Therapy in children with OCD.

You must be between the ages of 8 and 17 years old to be eligible for this study. If you are eligible to 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 8 weeks.

There will also be 3 psychiatric evaluations that take place. Two of these evaluations will be comprehensive and take about 3 hours each (immediately before and after treatment). During each of these, the participating child will have a small amount of blood withdrawn for lab tests. One evaluation will be short and take place in the middle of treatment. Study medication, treatment, laboratory tests, and the evaluations will be provided at no charge. Participants will also receive financial compensation for their time. If interested, please call Dr. Eric Storch of the University of Florida at (352) 392-3613.

**Help Us,
Help You
Please
Contribute to
the OCF
Research Fund**

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

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