OCD Newsletter

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Hair Pulling, A.K.A. Trichotillomania: A Simple Habit or Complex Diagnosis?

Dr. Steven Phillipson, Ph.D.
Clinical Director
Dr. Christopher Gibson, Ph.D.
Staff Psychotherapist
Center for Cognitive-Behavioral Psychotherapy

What is Trichotillomania?

Trichotillomania involves the anxious pulling or removal of body hair to such an extent that it produces a disruption to one's life functioning. This insidious condition is associated with feelings of depression, shame, anxiety and disgust. The term, "Trichotillomania," refers specifically to the final event (i.e., removal of body hair) in a sequence of behaviors or experiences that lead up to the actual hair pulling. Trichotillomania (TM), although often conceived of as a simple habit, has baffled behavioral psychologists and produced only moderate success in treatment outcome studies.

Thus far, TM has spawned debate as to under which of four different diagnostic categories it should fall. The official and historical classification of TM is as an impulse control disorder. This is the case even though research suggests that a significant number of TM sufferers evidence no urge to engage in hair pulling. The most likely diagnosis for the majority of suffers is a habit control disorder. Recently, there has been a great deal of debate as to whether TM is just another OC spectrum disorder. This debate exists despite evidence that anxiety plays a relatively small part in the justification for most hair pulls. Also, more than ten percent of those who engage in hair pulling

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OCD, Terrorism and War

The following articles were written by treatment providers and people with OCD in response to our question: Is the present state of world affairs having any effect on OCD symptoms?

OCD In The Age of Terrorism

David J. Keuler, Ph. D.
Charles S. Mansueto, Ph. D.
Ruth G. Golomb, M. Ed.
The Behavior Therapy Center of Greater Washington
Silver Spring, MD

The recent barrage of terrorist alerts in the Washington DC area and the ongoing war with Iraq have left many of us feeling anxious and uneasy. The threat of terrorist attacks seemed remote in the world prior to September 11th. Since then, images of terrorism flood our consciousness and threaten our sense of safety and security. Even the most stalwart among us likely shuddered when news agencies around the Washington DC area offered specific directives on how to seal ourselves into a room with duct tape and plastic sheeting in the event of a chemical or biological attack. Such concerns are part of our public consciousness, especially in the wake of the recent sniper attacks that resulted in school lockdowns, cancellation of major events and other unprecedented precautions in the D.C. area.

With such recent events triggering increased anxiety throughout the community, we wondered what the impact had been on the persons served by our therapy center. Specifically, we were interested in two questions. The first question is whether there has been an increase in requests for services at our clinic in the post September 11th timeframe, during the sniper attacks and anthrax scare, and now during the war on terrorism? Our clinic, The Behavior Therapy Center of Greater Washington (BTC), specializes in the treatment of obsessive-compulsive disorder as well as other types of anxiety disorders. It seemed

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From the Foundation

Dear Friends,

We just finished proof-reading this year's Conference Registration Brochure. This means that we're confident enough, after four tries,* that there aren't any fatal spelling errors, typos or mismatchings of presenters and topics, to allow the printer to actually output the Brochure. This is to let you know that we're certainly not above a little OCD behavior here at the Foundation and that a good behavior therapist could be kept busy just treating us.

Now, we're obsessing about starting on the actual Conference Program. Its production is where we engage in a lot of heavy checking because we have to get the presenters' names spelled correctly and titles right and decide whether or not we are going to put periods between M.S. and whether it is PHD or Ph.D. We usually change our minds enough times to add about 13 hours on to the drafting of the Program.

At the same time that some of us are exercising all of our creativity faculties to come up with 75 different ways to say "this presentation is about.....", others of us (we are a five-person staff, you know) will be calling (harassing is what the lawyer who threatened us with a restraining order called it) clinics, hospitals, suppliers and our treatment providers to politely inquire if they would like to buy an ad in the Program. Despite the Consent Order we entered into (under duress) with the Attorney General of the State of Massachusetts, I still say that threatening to put sand in Dr. Jenike's gas tank if the OCD Institute did not buy a full page ad

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In This Issue

Join Us In Nashville For The 10th Annual OCF Conference

Thoughts on the Effect of Terrorism and The War Against Iraq on People with OCD

By Chris V.

If the generally dreary "war on terrorism" had any upshot (no matter how ironic) for the OCD sufferer, it lay within the tragicomic spectacle of seeing the nation ravaged by paranoia, fear, irrational beliefs, and an overall feeling of doom and gloom – in other words, the whole country seemed to develop OCD overnight. Personally, it was hard not to feel a bit smug as government officials flip-flopped between dour warnings and clenched-teeth reassurances, citizens scrambled to buy duct tape or food supplies and politicians boasted about who had the safer state, the better precautions. The urge to yell, "Now you know how it feels!" or even "See: I told you the world is dangerous!" could be overwhelming.

At the same time, guilt and sorrow also rose. After all, if the average "Joe" down the street, who thought the Middle East was some hipster nightclub, is now memorizing the names of obscure provinces in Afghanistan and thinking twice about that flight to California, how is the OCD sufferer, already given to fits of apocalyptic paranoia and "better to hide under the covers than go outside today" thinking, going to feel? As cruel as the sight of non-OCD folks living their lives can seem when you're blinkered by OCD, it's also reassuring: you're forced to doubt your own worst fears and worries, maybe even wonder why you can't get a taste of that humdrum, everyday living yourself. It's bad enough to have OCD inside yourself; to have it (or at least some of its more blatant symptoms) ravage the world beyond you seems like a bad joke.

So what's left? For both the person without OCD and the person with, a hope that the "war on terrorism", if not won, will at least ebb away. For the OCD-afflicted individual, the bittersweet realization that even if life does go back to some sort of normality, and with it people revert to their usual selves, my world will still remain inside out.

OCD, War and Terrorism

Deborah A. Roth, Ph.D.
Edna B. Foa, Ph.D.
Center for the Treatment and Study of Anxiety,
University of Pennsylvania

At the Center for the Treatment and Study of Anxiety, we treat numerous patients with OCD at any one time. We have been on the lookout to see whether the recent war in Iraq, and more specifically the threat of bioterrorism, would impact the symptom presentation of our OCD patients. Interestingly, current events seem to have had minimal impact on the presentation of OCD symptoms. Of all the patients with OCD who we are currently treating, only one has exhibited symptoms associated with the threat of bioterrorism. At the time that we started to treat this patient, she had a room full of mail from the time of the Anthrax scare last fall and winter. Because of her OCD symptoms, she did not enter this room and was unable to open the mail. Over the course of exposure and ritual prevention therapy for OCD (see Kozak & Foa, 1997), she and her therapist did enter this room and succeeded in opening and going through all of the mail. The patient was pleased that she was finally able to confront her fear and to learn that nothing catastrophic happened as a result of touching these "contaminated" letters.

Why haven't our patients become concerned with bioterrorism during the war with Iraq? It is possible that the threat seems too remote for them to get particularly concerned. In contrast to Anthrax, which was on American soil (and in our geographic area), biological agents have thankfully not been released in the U.S. Furthermore, biological agents like smallpox and nerve gases are impossible to identify until they have struck. Anthrax, on the other hand, can be seen with the naked eye. We should point out though, that despite these differences between Anthrax and other biological agents, we have seen only two patients since the Anthrax scare who reported developing a fear of opening letters around that time. This observation is congruent with the fact that obsessional fears are often not connected to realistic concerns in OCD patients' lives.

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OCD NEWSLETTER

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Obsessive Compulsive Foundation, Inc.
Phone: (203) 315-2190
Fax: (203) 315-2196
e-mail: info@ocfoundation.org
www.ocfoundation.org
Janet Emmerman, President, Board of Directors
Patricia B. Perkins, J.D., Executive Director/Newsletter Editor
Michael Jenike, M.D., Chairperson, Scientific Advisory Board

The Obsessive Compulsive Foundation (OCF) is an international not-for-profit advocacy organization with more than 8,000 members worldwide. Its mission is to increase research, treatment and understanding of Obsessive Compulsive Disorder (OCD). In addition to its bi-monthly newsletter, OCF resources and activities include: an annual membership conference; popular website; training programs for mental health professionals; annual research awards; affiliates and support groups throughout the United States and Canada; referrals to treatment providers; and the distribution of books, videos, and other OCD-related materials through the OCF bookstore; and other programs.

The Menninger Clinic is Moving to Houston

The following is an interview with Throstur Bjorgvinsson, Ph.D., program director of the Menninger OCD Treatment Center, about The Menninger Clinic's move to Houston, Texas.

NEWSLETTER: The Menninger Clinic is moving from Kansas to Houston, Texas, on May 31, 2003. Why are you doing that?

BJORGVINSSON: We are affiliating with Baylor College of Medicine and The Methodist Hospital. This move will enable The Menninger Clinic to be true to our founders' mission of providing high quality research, education, and treatment. Menninger couldn't accomplish this without an affiliation with a medical school, which Topeka doesn't have. Baylor College of Medicine and The Methodist Hospital met all or our criteria. This affiliation enables Menninger to keep providing the specialty hospital services and the quality care that focuses on meeting the needs of the whole patient.

NEWSLETTER: Will your program stop during the move?

BJORGVINSSON: No, not at all. Obviously, a tremendous amount of planning has gone into this move. Because continuity of care is so important, we will continue to work with patients throughout the transition. Our plan is to continue to be open with callers about our plans and to assist them in scheduling their treatment. We remain open and staffed to continue taking care of the patients who seek out our programs. Our staff is, as always, committed to providing quality care.

NEWSLETTER: How is everyone getting from Kansas to Houston?

BJORGVINSSON: We have chartered an airplane for patients and members of the treatment teams. At the end of May, patients who need and want to continue their care with us in Houston will wake up at The Menninger Clinic in Topeka, Kansas and go to bed at The Menninger Clinic in Houston, Texas, all in the same day. Behavior therapists from the program will accompany patients on the trip to the facility. Our new location is still a campus environment with seven buildings on about 14 acres. The campus includes three patient living buildings, a freestanding gym and a dining room, and the school. Our new location is in the northwest part of the city – at the corner of Gessner and Kempwood. The address is 2801 Gessner Drive, PO Box 809045, Houston, TX 77280 (phones: 713-275-5000 and 800-351-9058).

NEWSLETTER: Is everyone going? Psychiatrists, psychologists, staff, patients?

BJORGVINSSON: I think it is important to mention that every employee at The Menninger Clinic received an offer to continue his or her employment with Menninger in Houston. For the Menninger OCD Treatment Center, I am pleased to report that the psychiatrist, psychologist, cognitive-behavior therapist, social worker, program nurse and several counseling staff are making the move. In preparation for the move and the new physical location, the Patient Care Services Dept. staff at Menninger has designed a comprehensive training program for all new staff. So, when we arrive in Houston, we will have a staff that is completely ready to be a part of our team approach.

NEWSLETTER: Are you going to use the move as part of your exposure & response prevention therapy?

BJORGVINSSON: We are always on the lookout for natural opportunities that come our way to complete exposure and response prevention sessions. Each patient has a unique set of OCD triggers and we will collaborate with each one about ways to tackle his/her fears. Behavior therapists will be on board the charter flight with patients making the move to Houston. We have many imaginal exposures planned for the trip, as well as specific ritual preventions. We are sensitive to each patient's progress in treatment and what he or she will be able to complete based on his or her hierarchy or behavior plan.

NEWSLETTER: How will the move affect your admissions? Will you stop admitting patients for a period of time before the move?

BJORGVINSSON: We will maintain admission scheduling throughout the transition – before, during, and after. As always, the patient's best interests are considered as we look at potential admission for treatment at The Menninger Clinic.

NEWSLETTER: What if a patient does not want to travel to Houston? What kind of discharge program will you be able to offer him or her?

BJORGVINSSON: We will continue to do for our patients what we always do – begin planning at admission for the patient's discharge and find an appropriate cognitive-behavior therapist in his/her area.

Actually, our current patients are enthusiastic about the move and the opportunities available in Houston. Amenities offered at the new campus include a swimming pool, gym, tennis courts, a softball field, and fitness trail. Patients are also very much aware of why we are moving and have openly discussed with us the significance of being connected with a major medical school and hospital.

NEWSLETTER: How are you going to ensure that no one undergoes any traumatic experiences during the move?

BJORGVINSSON: All patients currently in treatment were informed of our plan to move to Houston when they entered the program. As we do routinely in addressing life events and change, we have been actively thinking about ways we can, as a community of staff and patients, focus on supporting change during this exciting and challenging time. We openly talk about and address issues that patients may have about transferring to Houston. By doing so, we hope to minimize the stress that such a move may cause.

NEWSLETTER: What if a patient or mental health provider, for that matter, is afraid of flying?

BJORGVINSSON: Of course, as a cognitive-behavioral therapist, I will utilize the opportunity to help them overcome that fear! We have specific, focused interventions that can help individuals overcome such fears. For those unwilling or unable to use these services, ground transportation will be arranged. Menninger is committed to providing appropriate transportation for any patient. So far, we have not had anyone opt for the land route.

NEWSLETTER: How will you prevent panic attacks?

BJORGVINSSON: Being pro-active is likely to reduce that. For those patients who may be vulnerable to panic attacks, we are working now to help them increase their mastery of anxiety. There is no way to be absolutely certain that no one will have panic attacks during the move, but we will have a high ratio of clinical staff to patients on the flight to support those that may experience high anxiety.

NEWSLETTER: Will your treatment protocol change in any way?

BJORGVINSSON: No. We will continue our adolescent and adult programs, integrating behavioral, milieu, and medication therapies, and the same structure with intensive cognitive-behavioral therapy, focusing on individual behavior therapy plans for each patient.

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"Mirror, Mirror On The Wall"

An Interview with Dr. Eda Gorbis of the Westwood Institute for Anxiety Disorders, Inc., in Los Angeles, CA.

Newsletter: What is BDD?

Dr. Gorbis: Body Dysmorphic Disorder (BDD) is explained by the Diagnostic and Statistical Manual of Mental Disorders as a preoccupation with an imagined defect in appearance; and, if indeed, a slight defect is present the individual's preoccupation with that defect is markedly excessive. There is an ongoing debate among researchers regarding the exact categorization of BDD as a disorder; but many professionals consider it to be a form or subtype of Obsessive Compulsive Disorder. Nevertheless, the symptoms of BDD manifest as excessive concern with one's appearance or a particular part of one's body. The concerns are propelled by self-focused obsessions that generate significant levels of distress that disrupt one's ability to function. BDD is marked by excessive preoccupation so intense it makes it extremely difficult to focus on anything other than that body part or perceived flaw, provoking requests for reassurances from others as well as checking and seeking reassurance in any available mirror or reflection. A major symptom of BDD is a tormenting doubt. The underlying question is related to uncertainty about ones body part, or appearance. It is important to mention that symptoms can shift from concern about one aspect of appearance to another at any time.

Newsletter: Is BDD a symptom of OCD, or is it an entirely different problem?

Dr. Gorbis: BDD is seen as being related to a cluster of anxiety disorders including OCD, General Anxiety Disorder, Panic Disorder, as well as Bulimia and Anorexia Nervosa. The BDD fear structure is similar to that of OCD, but the obsessions and compulsions are specifically related to one's body.

Newsletter: How does someone know that s/he has BDD and isn't just concerned with a problem with his/her appearance?

Dr. Gorbis: BDD is not analogous to the common feelings of insecurity or appearance-related self-consciousness that most people have experienced at one time or another. Many people are somewhat critical of their appearance; and some people will go to great lengths in an attempt to change what they consider to be flawed. Plastic surgery is increasing in popularity; and more people are willing to take the risk of "going under the knife." A specific aspect of appearance can be surgically altered or "corrected" through procedures, such as, rhinoplasty (a "nose-job"). Many people who have had this procedure are happy with the results and can move on with their life. However, when BDD is a factor, the nose will never be perfect; or, if they are satisfied with the nose, another obsessive fixation on a different body part will take over.

A person suffering from BDD is subjected to high levels of distress that interfere with healthy functioning and his/her obsessions consume more than one hour daily. Furthermore, symptoms often disrupt interpersonal relationships and impair social and occupational performances. This physical fixation caused by the disorder distorts self-perception making it difficult for the sufferer to objectively appraise perceptions of his appearance.

It is not uncommon for people suffering from BDD to have a completely distorted perception of their own image. While they may be able to accurately appraise someone else's appearance, they cannot be objective about their own.

Newsletter: How much concern about "problems" with one's appearance signals that that person might have BDD?

Dr. Gorbis: It could be BDD if your concern with your appearance leads to excessive distress, withdrawal from social appearances or relationships, or even avoidance of public appearances as simple as going for a ride in a car or going to a swimming pool. Excessive concern about perfected appearance in dress, makeup, jewelry, and hair is also a symptom, which can result in spending from between one and 12 hours per day grooming.

These avoidances can progress to tragic proportions. In severe cases of BDD, we often observe repeated cosmetic surgical interventions that are uncalled for, inappropriate and unnecessary. The problem is that cosmetic surgeons, often due to difficulty in understanding and diagnosing BDD, are not able to identify BDD as the problem. The most extreme case that I saw in my practice involved a patient who had undergone 17 plastic surgeries; procedures most people would consider unnecessary and even dangerous.

It is not uncommon for people suffering from BDD to perceive their own image in such a distorted fashion that they believe their appearance is offensive to others. This notion reinforces the feelings of shame associated with BDD making it even more difficult to go out in public. It is notable they are often able to appraise accurately the appearance of others while at the same time they fail to objectively appraise their own appearance.

What people with BDD perceive is actually similar to the reflection we have all seen in a distorted carnival fun-house mirror. This concept actually led me to add a new approach to the method I use in treating BDD. It happened while working with a patient. I was trying to put myself in this patient's shoes, trying to examine his point of view. His description of how he saw himself reminded me of what I saw as a child walking through a "house of mirrors" at a carnival. This realization led us to develop a new therapeutic exercise; and we now use actual distorted mirrors for certain exercises during BDD treatment at Westwood Institute for Anxiety Disorders, Inc.

Newsletter: What are some of the symptoms of BDD?

Dr. Gorbis: Symptoms of BDD include (but are not limited to) excessive concern with a particular body part or aspect of appearance. The distress caused by this fixation can lead to compulsive behaviors, such as, repeated questioning and reassurance seeking, endless matching of clothing, social withdrawal, impairments or nonexistence of interpersonal intimate relationships, inability to tolerate social situations, constant checking for physical imperfections through touching, testing for bumps, feeling for symmetry, searching for flaws, skin picking, measuring the waistline, nose, counting hairs that fall out, etc.

Newsletter: Who gets BDD? More women than men? Younger people?

Dr. Gorbis: People with other anxiety disorders are more likely to be diagnosed with BDD due to the high co-morbidity of anxiety disorders. More men are treated for BDD then women. However, more research is necessary to see the exact distribution. There is some speculation that female BDD symptoms are more likely to be interpreted as "normal" female behavior and are likely to be overlooked and remain untreated. The onset of BDD is not exclusive to a particular age, though symptoms often emerge during teen-age years.

Newsletter: What causes BDD?

Dr. Gorbis: There are some theories, but the specific causes of BDD are not known. Many experts agree that sociological and biological factors play a role in the development of BDD.

Newsletter: What is the difference between concern about one's appearance and obsessing about supposed flaws?

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The Impact of Terrorism and War on OCD Symptoms: One Clinician's Perspective

By Anne Chosak, Ph.D.
OCD Clinic
Massachusetts General Hospital

Recent world events have increased stress and anxiety levels for many people across the globe. Just like people without OCD, individuals with OCD show a range of responses to specific stressors. OCD is a complex anxiety disorder with a number of components; and the impact of stress may be felt at many levels. It is often impossible to predict exactly what the effect of a major stressor will be for a particular person's OCD symptoms. Our only hint is the person's history of response to stress. Some people find that minor stressors increase symptoms while major stressors seem to decrease symptoms; others have just the opposite pattern. The nature of a person's OCD symptoms and her style of thinking about herself and the world can interact with change or stress in any number of ways. Some of my patients have literally not mentioned the terrorist alerts and Iraqi war; others have noted an indirect effect on their OCD symptoms because of increased general stress; still others have directly incorporated the world events into their OCD symptoms.

From a cognitive-behavioral perspective, it makes sense that intense, prolonged and universal stressors, such as, war and terrorist threats, would have psychological effects on some people. On the cognitive side, specific types of cognitive errors may be activated or exacerbated by such world events. Cognitive errors are common mistakes in reasoning, such as, "jumping to conclusions" or "black-and-white thinking." Such errors in thinking can lead us to feel more anxious and depressed than is warranted or useful. People with OCD may make cognitive errors around their obsessions and compulsions, but not necessarily in other areas of their lives. For instance, a person with contamination concerns might inflate the likelihood of harm if he or she touches a dirty wastebasket, but be quite accurate about estimating real danger from other sources.

In the context of terrorist alerts and the conflict with Iraq, many people with and without OCD have jumped to conclusions about the likely outcome of these events, and have in turn become depressed and hopeless. Some individuals have also tended to magnify the importance of particular events or have begun to spend a lot of time ruminating about them. While it is certainly appropriate to feel somewhat anxious or saddened by the prospect of war, terrorism, and loss of life, cognitive distortions promote excessive emotional responses that are unhelpful at best.

Along with increased or activated cognitive errors, there are often maladaptive behavioral changes during times of stress. For people with and without OCD, some amount of reduced activity is understandable. However, restricting usual activities deprives us of normal sources of reinforcement, pleasure, and identity. This in turn can lead to increased depression and anxiety. Decreasing activity levels can also directly impact the effectiveness of cognitive-behavioral treatment for OCD. For instance, individuals using exposure and response prevention (ERP) in the management of their OCD symptoms may experience decreased opportunities for naturalistic or planned exposure. This decrease in exposure opportunities can contribute to an increase in OCD symptoms in the short or long term.

Just as each person with OCD has a unique response to particular world events, each person needs to address maladaptive cognitive and behavioral patterns in a way that is targeted to his or her specific symptoms. For example, one of my patients reported that the Iraqi war and terrorist alerts had co-occurred with multiple life stressors. The total increase in stress had triggered both depressed mood and an increase in her OCD symptoms. In her case, the world events did not seem to be contributing in a way that was different from her other life stressors. In therapy, I encouraged her to practice stress management strategies in addition to keeping up with her regular cognitive and behavioral homework. She also increased her medication on the advice of her prescribing clinician.

Another patient became obsessed with details of the conflict and media coverage, compulsively analyzing events and ruminating about their potential negative impact. His other OCD symptoms, however, remained at a consistent level. During treatment sessions, we focused on rationally evaluating the world events and their likely/actual impact on him. And, I encouraged him to reduce his media consumption and compulsive analysis.

A third patient came to a therapy session early on in the Iraqi war convinced that we were all going to die any minute. Understandably, he was feeling quite depressed and hopeless. However, his drive to perform compulsions had decreased. His attitude toward the compulsions was, "what's the point" since he was so certain he was going to die anyway. We worked to evaluate his cognitive errors and generate rational alternatives, as well as significantly increasing his pleasurable activities.

Following successful treatment, a person with OCD may become able to handle stressful situations more appropriately. A young woman was ending a course of cognitive therapy with me as the Homeland Security alerts were increasing earlier this year. In the past, she had inflated the threat of any harm and took compulsive precautions accordingly. Prior to treatment, she would have compulsively prepared for a terrorist attack by plotting escape routes, purchasing every item in multiples from the terrorism survival lists, and hoarding them excessively. Now she was able to tell herself that she was adequately prepared for such an attack to the extent it was possible. She did look for duct tape in one store, but, when there was none, resisted the compulsion to go to other stores that evening. She was able to reason that the odds of an attack affecting her imminently were not very high, that she was as prepared as anyone else, that in fact there was nothing much she could do in the face of a nonspecific threat, and she would have to trust to her coping skills should something happen.

Based on the experiences of my patients during recent terrorist alerts and the Iraqi war, my advice to people with OCD would be to evaluate actual harm or risks as realistically as possible and to find rational alternatives for action other than compulsions. Compulsions may reduce anxiety and provide an illusion of control, but in fact they don't change reality or solve problems. Similarly, unless danger is objectively likely, don't shut down your normal activities. When we shut down, it is easy to become more depressed and more anxious. Make sure to get enough sleep, eat normally, and exercise regularly. Use any stress management strategies you have learned or used in the past. Make sure to engage in relaxing, enjoyable activities, such as, reading, taking a walk, seeing a movie, or spending time with friends and family. If you have a therapist, share your issues and symptoms with him or her.

As mentioned above, some of my patients coped with the terrorist alerts and Iraqi war by consuming endless media coverage. Of these, many reported that this led to information overload, hopelessness, and increased anxiety and depression. In such a case, I would recommend scaling back media consumption to a more comfortable level: perhaps scanning headlines, or watching half an hour of television news coverage, or listening to a single program on public radio.

Each person needs to find his/her own optimal balance of normal activity, healthy (not compulsive) awareness and safety behaviors, and preparation for likely events. Whether your OCD symptoms increase, decrease, or stay the same during stressful world events, work to keep your thoughts as accurate as possible and your behaviors as healthy as possible. Utilize your support systems sensitively and appropriately. Use your best coping strategies consistently.

Don't expect immediate improvement. If you are doing your best to cope, yet remain highly distressed and symptomatic, do consult with your psychopharmacologist, therapist, or physician about options to improve your therapeutic and/or medication regimens.

Research Digest

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

This month's articles emphasize behavior therapy which, for most patients with OCD, is the most effective therapy. There is a rub with behavior therapy; it's not widely available. For those who can find a capable behavior therapist, rapid, gratifying and lasting improvement is the rule. Making the point another way, two studies address the benefit of benzodiazepines, medications that are often prescribed for OCD. One found clonazepam (Klonopin) ineffective compared with placebo and the other found lorazepam (Ativan) interfered with behavior therapy.

Spontaneous decay of compulsive urges: the case of covert compulsions

Behaviour Research and Therapy, 41:129-137, 2003, P. de Silva, R.G. Menzies and R. Shafran

This study looked at behavior therapy, exposure with response prevention, for patients with covert compulsions. Covert compulsions are mental or cognitive rituals, such as, silently (mentally) saying phrases or mentally forming images in response to an obsession. Covert rituals have been more difficult to study than overt rituals, such as, cleaning or checking. As studies of exposure and ritual prevention therapy have shown repeatedly, the discomfort or anxiety associated with the urge to perform a mental compulsion lessens over time, when the mental compulsion is not performed. A significant finding was the rapidity with which the urges and the anxiety declined. Obsessions with urges to perform mental compulsions were provoked and after 15 minutes the urges and anxiety had returned to the pre-exposure levels. During ritual prevention, distraction techniques were used to help prevent the mental ritual, including activities, such as, reading, doing puzzles or doing mental math problems. One consideration is would the distraction strategy become a compulsion? These researchers believe this was not the case in their study.

The effects of single-dose lorazepam on memory and behavioural learning

Journal of Psychopharmacology, 16:345-354, 2002, A. Matthews, K.C. Kirkby and F. Martin

Benzodiazepines, such as, lorazepam (Ativan), are anti-anxiety medications often used for short-term treatment of OCD. Ideally, benzodiazepines should not be used long-term because they cause physical dependency. Also, there have been concerns that benzodiazepines may reduce the effectiveness of behavior therapy. Here lorazepam's effects on memory and learning, before, during and after treatment are assessed. Learning was assessed through a computerized exposure therapy exercise for OCD. In comparison to placebo, lorazepam impaired episodic and long-term memory, but did not affect short-term memory. Also, lorazepam significantly decreased learning in the exposure activity. This decreased ability to learn behavior strategies is possibly due to impaired processing of information into long-term episodic memory. These findings suggest caution in prescribing benzodiazepines with behavior therapy because benzodiazepines may lessen an individual's response to the treatment.

A double-blind, placebo-controlled trial of clonazepam in obsessive-compulsive disorder

World Journal of Biological Psychiatry, 4:30-34, 2003, E. Hollander, A. Kaplan and S.M. Stahl

Case reports, open studies and one crossover design study suggest clonazepam (Klonopin), a benzodiazepine, is effective in treating OCD. Here clonazepam was compared to placebo in a more rigorous 10-week parallel group double-blind study. Responders included 2 of 9 in the placebo group and 1 of 16 in the clonazepam group. As monotherapy (single medication treatment), clonazepam was not effective for OCD. As clonazepam has been effective for other anxiety disorders, it may be helpful for OCD patients with comorbid anxiety disorders. Also, it may be effective as an augmentation strategy, but that remains to be determined.

Group behavioral therapy for adolescents with tic-related and non-tic-related obsessive-compulsive disorder

Depression and Anxiety, 17:73-77, 2003, J.A. Himle, D.J. Fischer, M.L. Van Etten et al.

Many children and adolescents with OCD will have tics at some point in their lives. It has been suggested that tic-related OCD may not respond as well to cognitive-behavior therapy (CBT) as does non-tic-related OCD. This small, uncontrolled study compared the CBT treatment response of eight adolescents with tic-related and eleven adolescents with non-tic-related OCD. The group CBT program included patient education, exposure and ritual prevention, cognitive strategies and family involvement in the treatment. At the end of the 7-week group CBT program, adolescents with OCD and tics responded as well to cognitive-behavioral therapy (CBT) as adolescents with OCD without tics. These results suggest that the presence of tic disorders may not lower the response to behavior therapy for adolescents with OCD.

Repeated checking causes memory distrust

Behaviour Research and Therapy, 41:301-316, 2003, M. van den Hout and M. Kindt

In OCD, individuals with checking problems check repeatedly in an effort to prevent harmful events. They tend not to check once or twice, but much more often. This study looked at why distrust in memory persists despite repeated checking. An interactive computer animation program was developed in which participants had to perform checking rituals on a virtual gas stove. Repeated checking of the virtual stoves resulted in recollections of the last check being less vivid and detailed, and the participants became less confident about their memories of the last check. The checking became more familiar with increased checking, the memory of the checking became less vivid and detailed and this reduced confidence in memory about whether the last check was done correctly. This study suggests an answer to the question "why memory distrust continues despite repeated checking." Repetitive checking results in memory distrust; rather than reducing doubt, checking fosters doubt.

Exposure and ritual prevention for obsessive-compulsive disorder: effects of intensive versus twice-weekly sessions

Research Digest

Journal of Consulting and Clinical Psychology, 71:394-398, 2003, J.S. Abramowitz, E.B. Foa and M.E. Franklin

Behavior therapy by exposure and ritual prevention (ERP) is an effective treatment for OCD. Most treatment studies have used an intensive ERP schedule with daily sessions each week, a schedule that is often not possible in most clinic settings. Forty OCD patients received 15 sessions of ERP, 20 received daily treatment over 3 weeks and 20 received twice weekly therapy over 8 weeks. Results indicated that both programs were effective. The effect of therapy schedule was moderate, with a trend toward more improvement in the intensive group at post-treatment. No differences were found at a 3-month follow-up. Also of interest, some patients had additional mental disorders and histories of treatment failure. This study suggests that the benefits of ERP are not limited to highly selected research subjects.

Behavior therapy for medication nonresponders with obsessive-compulsive disorder

Presented at the 23rd National Conference of the Anxiety Disorders Association of America, March 27-30, 2003, Toronto, Canada. D.F. Tolin, G.J. Diefenbach, N. Maltby et al.

Sixteen adults with OCD, who had lengthy histories of failed medication trials and a high incidence of other mental disorders co-occurring, received 15 sessions of behavior therapy (exposure and response prevention). OCD symptoms were evaluated pre-treatment, post-treatment and at a 6-month follow-up. The OCD symptoms did improve during behavior therapy. However, the response was not as great as the response seen in studies of patients who had not previously been treated with medications and in patients with fewer co-occurring mental disorders. At follow-up, most patients maintained their treatment gains, but there was a higher-than-usual relapse rate. These results suggest behavior therapy is a treatment option for medication-resistant OCD patients, but response is likely to be modest. Researchers suggest medication-resistant patients may benefit from modifications to exposure and ritual prevention strategies. Modifications focused on issues related to motivation, medication compliance, co-occurring illnesses and family support.

The Menninger Clinic is Moving to Houston

(continued from page 3)

NEWSLETTER: Will you still be using milieu therapy in Houston?

BJORGVINSSON: We will continue to offer nursing support 24 hours a day, 7 days a week. As a treatment community, we offer various milieu interventions, such as, setting therapeutic treatment contracts with our patients. The goal is to help the patient focus on self-support. We strive to create a milieu that supports patient change and progress through constructive and supportive feedback from peers and clinical staff. Our patients seem to be able to take risks and make progress in treatment in such a setting.

NEWSLETTER: What additional services and benefits will the move allow you to offer patients?

BJORGVINSSON: Menninger is looking forward to being affiliated with Baylor College of Medicine and The Methodist Hospital, which are located in the Texas Medical Center, the country's largest healthcare complex. The educational and medical resources of our partners and the Texas Medical Center will ultimately enhance patient care at Menninger with innovative and cutting-edge perspectives of leading clinicians and researchers.

NEWSLETTER: Will the fees for services change?

BJORGVINSSON: Our fees will be the same when we open in Houston. We have no immediate plans for an increase in the cost of service delivery.

NEWSLETTER: Will the OCD program be covered by Medicare, Medicaid or private insurance? Will there be people who lose coverage because of the move?

BJORGVINSSON: We work with private insurance, and Menninger admissions coordinators are prepared to assist callers with questions or concerns they may have about their insurance benefits. Unfortunately, Medicare and Medicaid don't reimburse Menninger for our services.

NEWSLETTER: Will there be any changes in duration of your program?

BJORGVINSSON: Since our programs will remain the same in Houston, we expect that patient stays will still be in the ranges that we have experienced since we opened the OCD Treatment Center. Our average length of stay is about six weeks.

NEWSLETTER: Will there still be a school for adolescent inpatients?

BJORGVINSSON: For adolescents, a significant part of treatment at Menninger involves its accredited on-site school. Adolescents can continue their academic studies under the direction of certified teachers. In our new location, with support from a local school district, an on-site school will continue to be a part of The Clinic, enabling us to help students develop their educational, behavioral, social, and creative skills during their stay with us. Our current principal will relocate with us and continue to oversee the school program.

NEWSLETTER: What, if any, outpatient services will you offer?

BJORGVINSSON: It's not our intention to compete with local providers in the Houston area, so we will only offer specialty hospital treatment. In planning for discharge, we plan to collaborate with colleagues in the community who offer that level of care.

NEWSLETTER: Will the program expand? Will there be more staff?

BJORGVINSSON: The program in Houston is set up to accommodate 19 patients. As the number of patients increases, staffing will also increase to meet the needs of the program.

NEWSLETTER: What are the greatest benefits of this move for people with OCD and their families?

BJORGVINSSON: Menninger is known for quality care. One of the most important issues we have had to consider is the transfer of the Menninger philosophy of care. To do that successfully, members of the existing staff must be a part of the move. As I mentioned earlier, a large number of our staff is relocating.

Transferring experience in the form of talented and well-trained staff has been an important priority because our staff have always been at the center of what makes Menninger special. On the OCD unit, we hope to enhance treatment delivery, expand research, and improve outcomes. Additionally, Baylor College of Medicine, and The Methodist Hospital should prove to be very valuable resources for persons suffering from OCD and their families. We will continue to offer our full-day family educational day where we focus on family members of the patient and offer insight into treatment and ways they can support their loved one in reducing his or her OCD symptoms.

From the President

Dear Friends,

It is with pride that I can tell you that this has been a very productive time for the Foundation. We have several projects that are taking on a definitive shape and others coming to fruition. Our Education Task Force is finalizing the "how-to-do a presentation" booklet to accompany our video program, "How to Recognize and Respond to OCD in School-Aged Children." The Education Task Force was formed in 2001 with the goal of producing a program that would "educate the educators" of our kids with OCD about its effect on these kids and how they work and act in the classroom. After reviewing the video program and then meeting, it was determined that what was needed was a manual that parents and other interested volunteers could use to give presentations on OCD to teachers and other involved school personnel.

As I write this, Marlene Brill, a professional writer, is polishing the final draft of "Educating the Educators About OCD." This pamphlet explains in a step-by-step manner how to make a presentation about OCD that will assist your child's teachers not only to understand the disorder, but will also enable them to work with your child and his/her behavior therapist to get the OCD under control. Besides the booklet, the program includes transparencies and master copies of handouts.

The Task Force's next goal is to obtain financing for printing and packaging the program. Our staff is putting together grant proposals to request funding from private foundations that are concerned with children's mental health issues. And, of course, we can use your support for this program. I encourage you to mail a contribution, specially earmarked for the Education Program, to the Foundation.

We are hoping to have the program ready by the 10th Annual Conference in July in Nashville. We are hoping for enough funding to bring the writer to the Conference so that she can meet with parents who are interested in putting on the program in their local school systems and guide them in the procedure. Also, Edna and Bernie Bahr, Education Task Force members who have run the St. Louis Support Group for more than 13 years and have been pioneers in educating educators about OCD, are going to be available at the Conference to discuss their experiences instructing teachers about OCD in the classroom.

Late last year, we were given a grant by a Foundation supporter to build a "Hoarding Website." Our staff and our webmaster are presently working with Drs. Randy Frost and Gail Steketee to create a helpful and instructive website. To begin with, we are going to include the articles on hoarding that have recently run in the OCD NEWSLETTER along with treatment referrals and other resources. The site will be an add-on to www.ocfoundation.org in the same way as our teen webzine, "Organized Chaos" is. We are very interested in what you want to see on this web page. If you have any suggestions about content, please send them via e-mail to perkins@ocfoundation.org.

In early April, the third edition of "Organized Chaos," our teen "webzine," was unveiled. Aside from retaining some of the more popular articles from the first two editions, we added articles on how to manage your parents, an interview on how to avoid weight gain when taking SSRIs, an article on perfectionism, some poetry and an essay by a teen with OCD entitled "At the Kitchen Sink..." among other features. As of the beginning of April, according to our webmaster, more than 700 young adults have signed up for "Organized Chaos." Our plan is to put out three issues a year. If you would like information about how to log on for your teen, just call the Foundation and a staff person will give you the USER ID and the current password.

After a postponement because of the outbreak of the War with Iraq, the members of the OCF Genetics Collaborative met in Boston on April 26-27. These investigators discussed strategies for the genetic study of OCD. This included assessment instruments, types of samples, and phenotypes. They discussed the possible quantitative measures and assessment instruments that members of the group could use in order to facilitate the exchange of data and the current assessments being used by group members. They also discussed governance forms for the group and decided that they would work together as the OCF Genetics Collaborative with Dr. David Pauls of Harvard University and the OCD Clinic at Massachusetts General Hospital serving as the executive administrator supported by an executive steering committee and a range of other working groups. Before adjourning the members of the group made a commitment to work together with the goal of using their collective knowledge to find more effective treatments for OCD. I personally want to thank everyone who responded to our last plea for contributions for the Consortium. From making our plea in the Late Winter NEWSLETTER until the meeting, we raised $23,160.00. Thank you so much for making this meeting possible.

Another project that we have been working on is assembling all of the interviews with the Intensive Treatment Programs across the country on our website. When completed, people who are interested in this type of program will have all the information accessible in one place. Variations in programs can be easily examined so that a viewer can make a well-informed choice. The interviews are now on the website. You can read them on-line or download them from www.ocfoundation.org.

And, of course, the staff is working on the 10th Annual Conference to make this our best ever. We've scheduled 83 seminars, presentations, workshops and support groups. Participants will have sessions available from 7:45 am on Friday the 25th of July through early afternoon on Sunday, the 27th. No matter what your interests in OCD are, you will be able to find sessions to accommodate you. For more Conference information or a registration brochure, call Mary at the Foundation, 203-315-2190. Ext. 11. I look forward to seeing you there.

Best regards,

Janet Emmerman
President
OCF Board of Directors

Room Monitors Needed For the 10th Annual OCF Conference in Nashville July 25 - 27, 2003

We need OCF members to act as room monitors at this year's Conference. In return for serving as a room monitor for a day, a member will receive free registration for the 10th Annual Conference. Room monitors introduce the presenters (written introductions are provided), pass out and collect evaluation forms and handouts and help the presenter with slides and other tasks.

Anyone interested should contact Mary Grande at 203-315-2190, ext. 11 or email grande@ocfoundation.org by June 13, 2003.

The War, Terror and OCD

By Christina J. Taylor, Ph.D.
Associate Professor of Psychology
Sacred Heart University
Fairfield, Connecticut

9/11, anthrax, color coded threat alerts, suicide bombers, SARS, duct tape, airport security, smallpox, Saddam Hussein, Al Qaeda, Osama bin Laden, weapons of mass destruction, chemical warfare, coalition forces, prisoners of war, purple hearts, civilian casualties, civilian disorder, and shock and awe – we're living in a world turned upside down and inside out. Our souls, our hearts, and our minds are being tried to the breaking point and beyond; and, it really doesn't show any signs of stopping. Even the most healthy and secure of us are being challenged by the madness of this twenty-first century world. For people with OCD and other types of anxiety disorders, the heightened stress levels can be an even greater challenge.

When confronted with stressors, we experience heightened fear or anxiety, or what is called fight/flight activation. Nature has equipped us with this fear response so that we can take swift action to protect ourselves. None of us would survive without it. This was particularly valuable in early human history (and still is today) when threatened by attacking predators. Under such circumstances, our exquisite ability to respond quickly with an increase in heart rate, blood flow to our muscles, faster and heavier breathing, release of adrenaline, and heightened vigilance meant that we could defend ourselves by running from or attacking the predator. Then we could retire to our cave to recover and fight another day. Ah, the good old days!

Terrorism and the war on terror represent a different and potentially more insidious type of stress than the predators of old. Unpredictable and uncontrollable negative events are the most stressful stressors that we can ever face. As one of my patients put it, it's like walking around in a dense and overgrown jungle, gunshots sporadically firing off, sometimes close by and sometimes far away, with no way of telling exactly when or where they will occur. As a result, we walk around in a chronic state of anxiety and tension. And, if there is no time or place for relief from this tension, we become the walking wounded of the stress war. We can become more susceptible to illness and stress-related disorders, including a worsening of OCD and anxiety symptoms.

There are a variety of ways that the symptoms of OCD can be affected by the severe stress inflicted by war and the war on terrorism. The faulty beliefs commonly associated with OCD may make individuals with OCD vulnerable to experiencing a worsening of current symptoms or even the development of new symptoms. People with OCD often overestimate danger and the likelihood of harm, and place exaggerated emphasis on responsibility, control and certainty. The uncertain and hazardous times in which we live directly challenge such beliefs. Heightened fear can escalate these worries and concerns and consequently result in an increase and hardening of existing obsessive-compulsive symptoms.

For some with OCD, this anxiety translates into obsessive concern with information about the war and terrorism. Watching T.V. or spending time on the Internet may be a compulsive means of relieving anxiety – an attempt to achieve control, certainty, and order. The war in Iraq did, of course, cause most of us to experience a great upsurge of interest in the news. But the hyper-attention given to it by those with OCD suggests that they may be caught up in the OCD merry-go-round. Obsessional concern about safety, harm, threat and danger can lead to irrational attempts to reduce obsessional worries. One means of doing so is through compulsive information and reassurance-seeking. One of my patients spent so much time on the Internet that he fell terribly behind in his work and failed to meet important deadlines. Whereas the rest of us can and should get on and off the media merry-go-round, people with OCD and a compulsive "need to know" may be at risk for a much longer and bumpier ride.

Increased perception of threat is at the heart of increased stress levels. While we may all be experiencing increased worry and anxiety, individuals with OCD may be vulnerable to overestimating the actual likelihood of danger and harm in the real world. This may cause them to become more avoidant. Increased avoidance causes further increases in anxiety; and this in turn can cause an increase in any and all types of OCD symptoms. We see time and again that stress worsens obsessive-compulsive symptoms. During these tumultuous times, this can mean increases in obsessional worries and a worsening of compulsive behaviors, such as, checking, repeating, ordering, counting, arranging, cleaning, washing, collecting, list making, magical thinking and so on. Those of us in private practice who have observed an increase in the number of people seeking help since the 9/11 attacks continue to bear witness to the psychological devastation of terrorism and war. The war in Iraq has added an additional layer of fear and terror to the mix.

Nowadays, all of us are confronting matters of life and death more and more intensely. We have seen people lose their lives way too prematurely. We have seen the most youthful of soldiers captured, killed and injured. We have seen horrific images of death and destruction in far away places. Painful images are indelibly inscribed in the mind's eye. The photograph of the American military physician tenderly cradling a young Iraqi girl whose mother had been killed in the crossfire of battle is especially vivid in my own memory. There are hardly words to express the despair conveyed by such a picture. Being reminded of our mortality raises a host of existential questions about the meaning, value, and purpose of life, including questions about the ultimate mystery – death.

Anxiety about death is the most terrifying anxiety of all; and, it can certainly drive people to experience greater anxiety and more severe symptoms. Results of one study* showed that handwashing among obsessive-compulsive individuals was substantially increased under conditions that heightened awareness and thoughts about death and dying. In contrast, increases in compulsive washing did not occur in conjunction with a manipulation that invoked thoughts about the mundane unpleasantness of dental pain. Between terrorism and fears about SARS, it would be surprising if contamination fears were not heightened in the days to come for some people with OCD.

Individuals who suffer from religious obsessions and compulsions may be particularly vulnerable to stress during this time of war and terrorism. An individual, who questions God by asking how such horrors and cruelty can be inflicted on human kind, can experience great guilt and worry about committing sacrilege or blasphemy. He or she may come to fear that he or she will be punished or suffer in some way for these actions, consequently experiencing the need to reduce the anxiety through compulsive praying, atonement, and other superstitious rituals. I have seen this occur in one of my own patients who suffers with scrupulosity. In these extraordinary times, many of us without OCD find ourselves wrestling anew with the most essential questions about existence. It is therefore utterly understandable that those struggling with scrupulosity might be plagued with doubts about God, God's goodness, and the meaning of pain and suffering. All of which may very well instigate and reinforce obsessive-compulsive symptoms.

While it is clear that some individuals will have worsened anxiety symptoms under stress, whether or not they suffer from OCD, many individuals are able to sustain their health and well being despite the slings and

(continued on page 11)

**** Strachan, E., Pyszczynski, T. Greenberg, J. and Solomon, S. (2001). Coping with the inevitability of death: Terror management and mismanagement. In C.R. Snyder (Ed.), Coping with stress: Effective people and processes (pp. 114-136). New York: Oxford University Press.***

From the Foundation

(continued from page 1)

is not what I would consider an unfair and oppressive sales tactic.

Daisy and Leslie will shortly be cranking up the Apple Cube™ (that's what they said they were doing when they told me why I couldn't come in their offices) to produce the signs for the 83 presentations, seminars, workshops and support groups that we're offering at the Conference this year, including the Keynote Presentation on Saturday morning. Our keynote speaker this year is Dr. Dennis S. Charney, chief of the Mood & Anxiety Disorders Research Program at the National Institute of Mental Health. His talk is entitled "Psychopharmacology and Treatment of OCD and Related Conditions: Implications for the Discovery of Better Treatments."

These 83 sessions include presentations geared to people with OCD, to their families and significant others, to kids and adolescents with OCD as well as 24.5 CEU credits for mental health professionals.

Among the presentations is a centerpiece seminar on the Clinical Management of Treatment Avoidance with separate sessions for people with OCD and for their family members and friends. Dr. C. Alec Pollard, who wrote the article, "Someone I Care About Is Not Dealing With His OCD: What Can I Do About It?" with Heidi Pollard that was featured in the Summer 2002 issue of the OCD NEWSLETTER, has designed the respective sessions with the members of his staff at the Saint Louis Behavioral Medicine Institute. Drs. Steketee and Frost will lead another centerpiece seminar on hoarding.

This year there will be separate Orientation meetings on Friday morning for newcomers, children, and adolescents and young adults. For kids, there will be workshops on "Dissin' OCD." "Beating the Brain Bug," CBT, and their own G.O.A.L. Group, along with a hospitality room staffed by an art therapist and possibly a pool party. For adolescents and young adults, we've scheduled presentations on how to manage your parents, writing as therapy, dealing with being an adolescent on top of having OCD, self-injury, a transitions support group, and techniques for beating OCD along with possibly their own pool party and art activities.

For parents and family members there are seminars and workshops on how to maximize your child's chances of success in treatment, an update on medication for kids and adolescents, the special problems of an adult child with OCD, disruptive behaviors, parenting skills, contracting for recovery and how to avoid harmful reassurance and a special support group. Drs. Tamar Chansky and Aureen Pinto Wagner are doing two separate presentations just to help parents get comfortable with their children's OCD.

For treatment providers, there will be seminars and workshops on E&R techniques, medication, new areas of research, treatment of specific types of OCD and presentations on the OC Spectrum Disorders and their treatment. This year, they tell me, we are offering 24.5 CEU credits. Jeannette did the computation on our adding machine. It's another one of the instruments of modern technology I'm not allowed to touch around here. However, I rechecked it using my fingers and toes as well as Leslie's. So, it's an OCD approved number.

For everyone, there is "Medication: Questions & Answers," a presentation by Dr. Michael Jenike; a town meeting, a lecturer by Dr. Jeffery Schwartz on "Progessive Mindfulness," and one by Drs. Wilhelm and Steketee about "New Advances in Cognitive Treatment of OCD," and talks on Tics and OCD. Dr. William Hewlett is going to address "What is OCD, What It Is Not." Dr. Vladimir Coric, a young researcher from Yale, is going to talk about the results of his study of a new medication, Rizuole. Dr.Ben Greenberg of Brown University is going to discuss some of the alternatives to medication and CBT, surgery and deep brain stimulation.

Dr. Lisa Jo Bertman-Pate is going to lead anyone who is interested on "A Walk through Exposure and Response Prevention." And, Dr. Brad Riemann is going to show people how to create an exposure hierarchy. There are going to be seminars on symptom specific OCD and co-morbid conditions, such as, Trichotillomania, Body Dysmorphic Disorder, General Anxiety Disorder and Social Anxiety Disorder. (I'm not going to enumerate all 83 sessions because we'd never finish proofreading an article that long.)

Dr. Jonathan Grayson and the troops from the Anxiety and Agoraphobia Treatment Center in Bala Cynwyd and the Philadelphia affiliate of the OCF will be leading the "Virtual Camping Trip" this year around the grounds of the hotel and along the nearby riverbank on Friday night. On Saturday night, there will be a reception for which Jeannette is ordering the food. I'm not allowed to work on that part of the Conference either, because I insist on tasting everything, several times. We want to put on the third annual OCF film festival. Our only problem is that we are having a little trouble finding films. If you know of a film that was either written, directed or produced by a person with OCD or is about OCD, and/or the OC Spectrum Disorders, let me know. It would be a shame not to have an excuse for renting a popcorn machine again this year.

We're excited and anxious, very anxious, or as I like to characterize it extremely open to feelings of excitement (read that as a euphemenism for scared to death) about this year's Conference. After all, it's pretty special because it's the 10th and it will be in a really fun place, Nashville, in a very nice setting, the Gaylord Opryland Resort and Conference Center. Come and join us. We promise you it'll be great.

Ciao!

Patricia Perkins

Patricia B. Perkins
Executive Director

*Ooophs! We should have done it five times. Somewhere between the third and fourth readings we lost Dr. Joseph Ciarrocchi's seminar, "Scrupulosity: Seeing Sin Where It Is Not," (Friday, July 25 at 9:00 am) and Drs. Grayson and Mansueto's sequel to last year's presentation on "Views Inside the Therapist's Mind." And, we also goofed by listing Dr. Karen Landsman instead of Dr. Lori Kasmen in "Take It From Me, You Can Beat OCD." There's an E&RP lesson in here somewhere. We shouldn't have continued checking.

Thank you to Miriam & Robert Boucher and Mrs. Rosa Hayward Jones, who also contributed to the OCF Research Fund between November 11, 2002 and March 17, 2003, but were inadvertently left off the list.

My OCD Notebook

What Does Habituation Mean?

By Bradley Riemann, Ph.D., Director of the OCD Center at Rogers Memorial Hospital

Exposure and ritual prevention (ERP) has been found to be very effective for treating obsessive-compulsive disorder (OCD) over the last 35 years. We know that as many as 85% of people with OCD can be helped by using ERP. However, many OCD sufferers and their families are confused by some of the terminology associated with this technique. One very important term that confuses many is "habituation". My goal in this brief article is to help clarify what this term means.

ERP is based on the principle of habituation. By nature, people habituate to negative things around them. In a sense, habituation means getting "used to" something we don't like. For example, after being in a room for a period of time, we no longer hear the hum of a fan that we first found distracting. The sound does not go away; we just got used to the sound and, therefore, no longer perceived it. Another example of habituation we can all relate to is water temperature. When we first jump into water we may find that it is cold, but if we stay in it long enough we find that the water has "warmed up." Again, the water hasn't warmed up, we have just gotten used to it or habituated to it. If you were to get out of the water for a while and jump back in, you would find the water to be as "cold" as it was the first time. The process of habituation is normal and natural, and takes no effort on our part to occur.

So what does this have to do with anxiety and ERP? With respect to anxiety, habituation refers to the decrease or reduction in anxiety with nothing but the passing of time. This means that our anxiety about something we fear will eventually go down without doing anything but letting time pass.

In ERP we look for two types of anxiety habituation. First, there is "within trial" habituation or reduction of anxiety. A "trial" in ERP refers to an exposure assignment that you are attempting (e.g., touching a doorknob and not washing your hands). "Within trial" habituation is the reduction in anxiety you get while holding onto the doorknob over a period of time (e.g., your anxiety reduces from a 4 to a 2 using a 10-point scale in 10 minutes). You will get this anxiety reduction if you give yourself long enough without doing (e.g., washing your hands), thinking (e.g., thinking to yourself a prayer), or saying (e.g., asking if it is ok to touch a doorknob) anything. Your anxiety goes down with nothing more than the passage of time. The key to "within trial" habituation is to do the exposure exercise long enough to experience this reduction in anxiety. Using the water temperature analogy again, you must stay in the water long enough so it can "warm up". How long is long enough? It is different for different people; and it is different for different exercises. Most doctors would encourage you to do the exercise until you get at least a 50% decrease in your peak anxiety rating (i.e., when it was at its highest point during the trial, say from a 4 to a 2). Typically, the more challenging the exposure exercise is for you the longer it will take to experience "within trial" habituation.

The second type of habituation sought in ERP is "between trial" habituation. This refers to the reductions in the "peak" anxiety ratings you experience when you repeat the exposure exercise over and over again. The "within trial" reductions in anxiety that we have already discussed do not last long if the exposure exercise is not repeated. This means that if you saw your anxiety go from a 4 to a 2 in 10 minutes on a particular exercise and then waited a week before you did it again, you probably would get an anxiety rating of a 4 to a 2 in 10 minutes again. The end result is nothing changes without repeating the exposure exercise in a time-intensive enough fashion. It's like getting out of the water and not going back in until the next day. Chances are, it will feel as cold as it did the day before. It takes repetition to get your peak anxiety ratings to reduce from one trial to the next. With enough repetition you can get to the point where an exposure exercise will cause you minimal anxiety from the start of that exercise. How many repetitions will it take before you experience minimal anxiety from an exercise? It is different for different people and different for different exercises.

"Between trial" habituation is really the effect of treatment. Rituals or compulsions give you the equivalent of "within trial" habituation. Compulsions work, and can work, to reduce anxiety quickly (e.g., driving anxiety from a 4 to a zero). Obviously, the problem is that they don't help in the long run and every time someone is faced with that same situation they will have to ritualize again. Exposure without repetition is the same thing. It reduces anxiety at first; but if you don't keep doing it, nothing good happens in the long run. ERP "beats" compulsions with the "between trial" reductions or habituation that occurs with repetition. In a sense, the goal of ERP is to replace the compulsions with the process of habituation as a means of reducing anxiety.

So, when doing ERP remember to do the exercise long enough to get "within trial" habituation, and repeat it enough times to get "between trial" habituation. Good luck!

The War, Terror and OCD

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arrows flung at them from the outside world. Plainly, some people are able to shield themselves from even potentially devastating stressors. In times of war, this can be seen among soldiers who are able to cope with the enormously severe dangers of battle. The traumatizing ordeal of Private Jessica Lynch embodies the violent brutality that soldiers must sometimes endure – and yet they do so with courage and faith.

Research on stress shows that there are a variety of factors – personal qualities and actions – that help us in the stress war. Those who cope best with stress tend to view stressors as problems to be solved rather than as overwhelming or insurmountable obstacles. They also see themselves as capable of coping – adopting a "can do" attitude about stressful events and situations. Such assuredness and confidence reflect belief in one's ability to exercise control over the stressors that come one's way. And if literal control is not possible, one can exercise acceptance – to paraphrase the "Serenity Prayer" – to change the things we can, to accept the things we can't, and to have the wisdom to know which is which.

The war in Iraq represents a different kind of war than the Gulf and Vietnam Wars because we have been immersed in the war on terror since 9/11. Living in wartime means that we need to marshal all our coping resources to survive. In addition to holding onto a belief in our abilities, we need to hold on to one another for support. Social support is critical to maintaining well-being. It is our safe haven in the midst of stress. Other very practical actions help as well, including exercise, pleasant events, meditation, daily mini-breaks, and, very importantly, using and enjoying humor. All of these things buoy us and help to give us relief from the turbulence in which we are immersed.

For the stressed who also have to cope with OCD, coping well means having the confidence that they can control and manage their OCD through the tried and true techniques of behavior therapy – Exposure and Response Prevention. If you need to bolster yourself, pick up a good self-help book on behavior therapy techniques, revisit or find a skilled therapist, revisit or find a qualified spiritual advisor, evaluate and explore medication options, attend a self-help group, call on family or friends for assistance, use the Internet in a balanced way for information and support, and attend workshops and conferences. Above all, have courage, practice exposure, and don't avoid!

Trichotillomania

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report no tension release following an episode. The presence of perfectionist tendencies is almost never mentioned in association with TM; yet a large number of sufferers report that the search for perfection is the driving force behind most pulling binge episodes.

Our belief is that the rationale for hair pulling points to a differential diagnosis. This differentiation can have a significant impact on the selected treatment strategies. Additionally, the shame, disgust and self-loathing most often associated with the act of hair pulling has been pervasively neglected as an essential portion of a successful treatment. Because hair pulling is the result of multi-determined behavior, a clinician needs to discover the motivation behind a patient's hair pulling before designing a treatment course.

The Grooming Response and a Sequential Analysis of Trichotillomania

To understand TM, it is essential to explore a prevalent precursor to the actual hair pulling behavior that exists in most of the following conditions. Prior to hair pulling, most sufferers engage in a self-stroking behavior otherwise known as the "grooming" response (i.e., hair twirling, eyebrow caressing, pubic hair tweaking, etc.). In most cases, this portion of the habit serves as a self-stimulation component and provides the mind with a positive experience during what are otherwise low activity times in the sufferer's life. Others find this stroking behavior to be soothing in times of stress.

Following a hair pull, many individuals engage in behavior that further rewards the act by creating increased stimulation. This might entail chewing on the root of the hair or playing with the follicle. Very little is known about why individuals engage in such elaborate post-pull activity. However, these acts intensify the shame that the sufferer experiences. To formulate an effective treatment, a clinician needs to learn about the patient's particular behaviors and experiences just prior to and following the actual hair pull. These acts usually explain the powerful reinforcing elements that make the condition hard to eliminate. A sequential analysis also reveals what role personality plays in maintaining or justifying the hair pulling.

More than Just a Hair Pull

Hair pulling could be subsumed under four separate diagnostic categories: 1) a Habit Disorder, 2) Obsessive Compulsive Personality Disorder (OCPD as in perfectionism), 3) Obsessive Compulsive Disorder, or 4) an Impulse Control Disorder.

Habit Disorder

The definition of a habit is the repetition of a behavior for the purpose of producing stimulation (during low activity times) or comfort from tension. The behavior is repeated due to the rewarding properties of the action. The excessive nature of the behaviors of TM (i.e., the enormous time devoted to engaging in the process) serves as an avoidance of life endeavors or creates cosmetic challenges. Often the most troublesome aspect of a habit is the patient's perception that he or she is acting in an "out of control" manner. When a sufferer tries and fails to stop the behavior, s/he becomes very frustrated. Habits are often engaged in without the person's conscious choice or awareness. It is usually at the end of the habit session that the actor becomes aware of engaging in the behavior.

The following is an example of hair pulling as an habitual behavior. John, at age 13, started to spend much of his free time, while watching television or talking on the phone, twirling and weaving his hair. At first, playing with his hair follicles seemed to provide a certain sense of stimulation. Eventually, John noticed that he gained a sense of gratification from pulling out hairs that were, in some way, different or coarser than the others. After plucking out a hair, John would become fascinated with the tip of the hair follicle and often manipulate it, play with it, or periodically chew on it. When John was 18, a barber noticed he had a thin spot and asked him whether any of the males in his family had premature balding. John was so mortified by this question that he suffered a panic attack. After this incident, John started wearing an old baseball cap so that no one else would notice the baldspot. On occasion, he would wear his cap when he was alone to keep his hand away from his hair. This strategy did not work and neither did his girlfriend's slapping his hands when he touched his hair. John eventually sought professional help when his college dorm hallmates made fun of him for always wearing a hat. The treatment prescribed for John was habit-reversal training (HRT) and cognitive therapy for depression and shame.

Perfectionism

Hair pulling as perfectionism entails the rigid effort to exert excessive control over circumstances in pursuit of an outcome that does not have any perceived flaws or incompleteness. Perfectionism is generally a dispositional handicap in which one's beliefs are detrimental due to their rigid nature. A perfectionistic disposition is aimed at managing one's image. For example, a perfectionist might be motivated by the need to keep others from seeing what s/he perceives as flaws. A perfectionist's self-esteem is so fragile that it can be seriously damaged if s/he feels that someone has seen these perceived imperfections. Some are driven to be perfectionists by the need to maintain their belief that they are "good" people.

Perfectionist behaviors include: writing and re-writing for the purposes of producing the best outcome, redundant and excessive cleaning, or placing objects exactly. People can also be perfectionistic about their appearance, such as, tweezing hair to achieve perfect symmetry and uniformity or picking one's face to remove all perceived blemishes. For example, Lisa, at age 16, was going to her first prom and a beauty consultant gave her make-up tips, which included tweezing her eyebrows. She felt that her good time and popularity that evening were directly attributable to her appearance. Lisa thought her tweezed eyebrows made her more attractive. To stay attractive, she started tweezing her eyebrows daily. It was only a short period of time before Lisa found that she didn't feel attractive until she removed every unruly hair. Eventually she graduated to using a magnifying mirror to find any hairs that strayed outside of her chosen eyebrow line.

Lisa's daily tweezing provided her with a misguided sense of being in control of others' perceptions of her. She began to believe that as long as her eyebrows were maintained perfectly, life would be less threatening. Lisa's primary motive for tweezing was to achieve the perfect eyebrow line, which then would make her feel confident about her looks and herself. She thought erroneously that only negligent people had messy eyebrows. So, if she had unruly eyebrows, people would think she was a messy person.

Lisa found herself spending hours in front of her magnifying mirror. She reported that during these times, what seemed like five minutes of hair pulling or tweezing, was actually two to three hours. This trance-like state, where time becomes distorted, is a common experience for Trichotillomania patients. Lisa told no one about her tweezing. She thought that this behavior meant that she was emotionally sick and depraved. She did not seek help until her hair pulling was out of control.

Obsessive Compulsive Disorder

In Obsessive Compulsive Disorder (OCD), an individual experiences anxiety related to the possibility of a focused threat, and works hard to dispel the anxiety by obsessing or performing compulsions. The most common forms of OCD involve elaborate rituals with mental problem-solving, cleaning, or checking.

Recently, clinical investigators have started to write about OCD's focus on the anxious effort to remove an unwanted thought or experience. TM sufferers fixate on the belief that in every waking moment they will be

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Trichotillomania

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distracted by a nagging reminder that "the bad hair is still there." The ritual, in this case, hair pulling, is performed to absolve the mind of the reminder that the hair is still there and allow for clearness of thought to prevail. The hair pulling is also linked to an ardent belief that one's unattractiveness or body hygiene can be mediated by removing unsightly hairs. This type of OCD is known as Body Dysmorphic Disorder (BDD).

TM/ Classic OCD

While playing with her hair, Joan periodically notices that some of the follicles are more coarse and kinky than others. The awareness of the "aberrant" hair distracts her. She fears that the distraction will persist until she locates and removes the different hair. Therefore, she must get rid of the "bad" follicles. Because of this obsession, her concentration at work is impaired and she makes more mistakes. This actualization of the threat makes her believe that she is really losing control. She responds by being more conscientious about removing all of the distracting hairs. Joan finally seeks professional assistance. She learns to wear a rubber band around her wrist and snap it when she pulls her hair. She is also instructed to clench her fist when she experiences the urge to pull and keep her fist clenched until the urge passes. After four frustrating months, with minimal success, she reads an article on OCD and contacts an expert in the field realizing that this may be her problem and that she may need a different type of treatment.

TM/Body Dysmorphic Disorder

Samantha was always self-conscious about her appearance. She rationalized that since she would some day be an actress, expending more effort in making herself look attractive was justified and sensible. Samantha became more aware of certain hairs above her lip and on her legs. This awareness made her self-conscious about her appearance and made her feel dirty. Despite regular electrolysis and reassurance from friends, Samantha believed she was hairy and disgusting and continued in her pulling efforts.

One afternoon, Samantha perceived that one cheekbone seemed to be higher then the other. She thought this made her ugly. After repeatedly talking with her family and friends, she finally consulted a plastic surgeon, who made the appropriate diagnosis of BDD.

TM/Impulse Control

Conditions resulting from an impulse control disorder involve an irresistible urge to act immediately. Just as a person with Tourette's Syndrome feels an overwhelming urge to bark out sounds or profanities, hair pullers mentioned the experience of feeling the "need to just get rid of the hair." These hairs just seem to stand out, not because they are wrong, but just because they seem different in some way.

The Role of Shame in TM

A profound sense of shame tends to permeate each of the above-mentioned subtypes of hair pulling. Shame results from the existence of a perceived defect within a person, which contributes to a loathsome and/or depraved identity. It also encompasses a desperate need for the focus of the shame to be kept hidden from the world. In many cases of Trichotillomania, the associated shame produces the greatest debilitating effects. Therefore, making shame one of two essential features that distinguish TM as a separate disorder. The degree of life's disruption is the second element necessary for a diagnosis.

Sufferers try desperately to hide their disorder. The need to conceal is so extreme that it is not unusual for persons to hide their hair-pulling behavior from loved ones. Many individuals with this disorder often report significant social avoidance secondary to balding. Some will avoid events that are most likely to expose their alopecia (hair loss) for fear of embarrassment.

When confronted, it is common for sufferers to deny having the disorder. Frequently, they will attribute the hair loss to a "medical condition" or a "reaction to a medicine." Given the stress, social isolation, and shame that are associated with TM, it is not surprising that a significant number of individuals with this disorder also suffer from depression, anxiety, and substance abuse problems. These difficulties only add to the sufferer's stress level, often increasing the urge to pull their hair. The outcome is a vicious and self-reinforcing cycle.

Despite the prevalence of hair pulling in the non-clinical population, people with TM believe that they are corrupt for engaging in this seemingly sick and disgusting behavior. The vast majority of sufferers hold firmly to the notion that any "normal" person would be justified in rejecting them for having this horrific condition. Sufferers need to be taught to relate to their humanness, rather than to perceive themselves as being loathsome. In this area, strategies pertaining to cognitive restructuring (CBT) are essential.

The Hidden Rewards of Hairpulling

For some individuals, prolonged periods of hair pulling may provide an almost narcotic-like experience. So, it is not a surprise that most persons with TM report that the condition is exacerbated during periods of stress. The hair-pulling sequence distracts the hair puller so that daily stressors seem to fade into the background and lose their emotional presence. This hypnotic-like effect is what causes pullers to get lost for hours in hair pulling episodes. Persons will often rationalize putting off their obligatory tasks until they complete the daily grooming ritual.

These hidden rewards are called "secondary gains". A secondary gain refers to a "benefit" that a patient might reap by avoiding, escaping, or otherwise "not being able to" engage in a behavior as a function of being preoccupied with another behavior. These gains are the possible reasons that a seemingly self-destructive behavior might be so treatment-resistant. For example, a patient who feels awkward meeting new people might spend endless hours engaged in eyebrow tweezing, rather than face the potential humiliation of being rejected at some social affair. Before a thorough treatment strategy can be formulated, these secondary gains must be given careful consideration to ensure that the patient does not undermine his or her success because of them.

Treatment Considerations

One of the most debilitating aspects of TM is the belief that stopping is just a matter of "will power." Most of us like the idea of free will. This belief discounts the fact that a great deal of the actions takes place below one's level of awareness.

Hair pullers entering behavioral psychotherapy tend to have a history of multiple failed efforts at bringing this condition under control. Often, the methods used to self-treat closely approximate those that would be suggested by a qualified psychologist. We believe that effective treatment is multifaceted. A single strategy that does not take the full diagnostic picture into account will most often fail in the long run. The therapist needs to treat TM with a variety of interventions tailored especially to the patient.

Summary

This article has attempted to introduce the idea that TM is probably a single behavior (hair pulling) with, at least, four subclassifications. There is a significant percentage of the TM population whose symptomology qualifies them for more than one classification. Given the diversity of diagnoses associated with TM, it is imperative that the clinician and patient work together to ascertain the specific nature of the condition before beginning treatment. The importance of shame in this disorder has to be acknowledged and treated, as it causes the most debilitating effects. The arguments over whether Trichotillomania exists within the OC Spectrum or is just a bad habit should be replaced with the development of specialized treatment protocols that address the specific nuances of this complex condition.

"Mirror, Mirror"

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DR. GORBIS: When concern with one's appearance interferes with social/occupational performance, it may be a symptom of BDD. Simply put, if a person's appearance becomes the center of his focus and he can no longer maintain a healthy perspective on life, it has become an unhealthy obsession.

NEWSLETTER: How can BDD impact a person's life?

DR. GORBIS: The degree to which BDD affects one's life depends on the severity of the symptoms/condition as well as the person's ability to use mindfulness, a necessary practice for treating the disorder. BDD symptoms can cause one to avoid public places and social situations, undergo multiple and unnecessary plastic surgeries, be house-bound, cause low self-esteem, depression, anger, anxiety, eating disorders. In severe cases, it can even lead to suicide.

NEWSLETTER: Do people with BDD actually see themselves differently or are they interpreting what they see differently? Do they imagine flaws and imperfections or do they misperceive what they actually see?

DR. GORBIS: People with BDD misperceive what they see. There is misinterpretation and distortion about the actual situation or features.

NEWSLETTER: Do people with BDD experience a kind of paranoia about their perceived flaws? Do they believe or feel that others are taking special notice of their "defects," staring at or laughing at them?

DR. GORBIS: People with BDD certainly do experience extreme self-consciousness. BDD leads people to sense that other people are criticizing their perceived imperfections. Around others, they get the feeling of being scrutinized under a magnifying glass. As these fixations intensify, the belief that people are looking at the perceived "defects" seems rational. The actions of others are interpreted in reference to the particular "flaw" and it seems that people are starring, laughing, and discussing them behind their backs.

NEWSLETTER: Is the person with BDD literally delusional about the existence of the flaws or imperfection he feels he has?

DR. GORBIS: BDD, just like OCD, ranges in its severity. The level of insight may actually be evaluated as good to poor or extremely poor. People with extremely poor insight may be close to overvalued ideation about the imperfections that they think they have.

NEWSLETTER: What kinds of compulsive behaviors do people with BDD perform?

DR. GORBIS: Compulsive behaviors of people with BDD vary depending on their "area of concern." For example, if someone is concerned with his nose, he might touch it, check it in the mirror or any reflecting surfaces, get plastic surgery, and try to endlessly perfect it. In general, symptoms include seeking reassurance, body checks, and checking one's image in any reflecting surfaces.

NEWSLETTER: Does a person with BDD typically ask family and friends for reassurance about his appearance or try to convince them that he is ugly?

DR. GORBIS: People with BDD typically ask for reassurance. However, responses to repeated questioning lead to other questions in different forms that are underlined by uncertainty. These compulsions result in no relief but rather serve to reinforce the false belief system and unhealthy fixations leading to further compulsive questioning and on and on.

NEWSLETTER: Does BDD interfere with an individual doing his job, managing a household or maintaining relationships with friends and family?

DR. GORBIS: One problem of BDD is that it handicaps one's relationships and functioning. A sufferer might be so concerned with having her hair done perfectly, that she will not be able to even leave the house, or have time to do anything else except doing her hair.

NEWSLETTER: Do people with BDD have problems leaving their homes, shopping, engaging in work and play activities?

DR. GORBIS: People with BDD believe that some aspect of their appearance is not perfect. They spend endless amounts of time and a lot of effort trying to perfect that particular aspect of their appearance. If their "area of concern" is not perfect [it never is], they are reluctant to leave the house or continue with daily activities. It is not only that they know that they are not perfect, but also they believe that they will be highly scrutinized by others (watched under a magnifying glass). All these factors make it difficult for people with BDD to go on with even routine daily activities.

NEWSLETTER: Are there treatments for BDD? What are they?

DR. GORBIS: There are treatments for BDD. One of them is Cognitive-Behavioral Therapy (CBT) which uses Exposure and Response Prevention (E&RP). Also it can be useful to add Mindful Awareness Training, Cognitive Restructuring and Socratic Questioning to CBT. At our Westwood Institute for Anxiety Disorders, we have been using videotaping and objective self-portrait description in writings. We have also recently ordered numerous distorted mirrors that are used in exposure exercises to help patients intensify the distortions. This technique has been successful so far. At our Institute, we commonly use a combination of medications and CBT. We often employ an interdisciplinary team to work on each case and treatment is tailored to each case. We also have five psychiatrists that are OCD and anxiety disorder specialists.

NEWSLETTER: Are there medications that are effective?

DR. GORBIS: Medications may or may not be effective. Each and every case is different. For people with high base anxiety, medications may be used to reduce the amount of experienced anxiety. In some cases, medications can also be used to alleviate other psychological disorders that are present and may interfere with the treatment of the BDD (e.g., depression, panic attacks). However, some kind of therapy is required in addition to the medication.

NEWSLETTER: Is Cognitive-Behavioral Therapy an effective treatment for BDD?

DR. GORBIS: Cognitive-Behavioral Therapy has been proven to be highly effective in treating BDD. At our Institute, we have had many cases of people who have been treated with CBT and have gotten great outcomes.

NEWSLETTER: What can family members do to help a person with BDD?

DR. GORBIS: A family's understanding, support, and love are required. Often, people misperceive BDD symptoms as evidence of the sufferer being shallow and self-absorbed. It is very important for families to understand that BDD is a disorder. It requires treatment. It is also extremely important to help one find appropriate help as soon as possible because the symptoms might worsen.

If you would like to learn more about BDD, you can contact the Neysa Jane BDD Fund at neysabdd@comcast.net or Eda Gorbis, Ph.D., MFCC, at the Westwood Institute For Anxiety Disorders, Inc. 921 Westwood Blvd., Suite 224 Los Angeles, CA 90024, Phone: 323-651-1199.

OCD In The Age of Terrorism

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reasonable to assume that increased anxiety in the general population might spawn increases in requests for psychological services. Several of our clients had commented to us playfully that the recent terrorist alerts and sniper incidents "must be good for business." Was it, in fact, true that these horrifying events resulted in an increase in individuals seeking treatment at our clinic? Secondly, we wondered whether terrorism was affecting clients already in treatment at BTC, and if so, how? For our purposes we defined terrorism as the September 11th attacks on the World Trade Center and the Pentagon, the subsequent anthrax scare, the sniper attack, as well as the frequent terrorist alerts issued by the Department of Homeland Security following these events. We conceived of four possible ways that terrorism might impact our clients, either alone or in combination:

1. Clients might experience a worsening of their existing OCD as a result of an increase in overall anxiety.

2. Clients might experience a worsening of their OCD as a result of incorporating new, terrorist-related obsessional themes into their symptomotology.

3. Clients' OCD might be unaffected by terrorism.

4. Clients might experience an improvement in their OCD, perhaps because terrorism might serve to distract them from their previous concerns, or for other reasons.

In order to answer questions about terrorism's impact on rates of requests for services and effects on existing clients, we reviewed the clinic records and conducted an informal survey of our clinical staff. The clinic intake records contained the number of requests for new services and, thus, would provide information on requests for services as well as the nature of the problem requiring attention. Time constraints (including the deadline for this article) precluded a rigorous study of the impact of terrorism on our clients. However, we felt that gathering information on the therapists' impressions would shed light on the issue and contribute to ongoing discussions on the impact of terrorism in clinical populations. Therefore, each of the clinicians was asked to consider the four possible effects of terrorism on OCD as noted above and to estimate the percentage of their caseload that conformed to each. The BTC clinical staff is comprised of 10 psychologists, 2 clinical social workers, and a certified professional counselor. The staff provides weekly psychological services for over 100 clients with OCD as well as a number of clients with other varieties of clinical disorders. Approximately two-thirds of these clients are adolescents and adults.

Impact of Terrorism on Requests for Psychological Services

A review of clinic records showed no increase in the number of requests for services since September 11th compared to the previous three years. In fact, requests for services have remained surprisingly unaffected by the recent threats to area residents. As such, the recent terrorist acts and threats *have not* been "good for business" (we are happy to report!). One explanation may be that individuals only seek out psychological services when they believe that their anxiety is excessive or irrational relative to those around them. Since so many people have openly expressed considerable anxiety regarding the terrorist threats, few individuals may perceive their anxiety as either excessive or irrational. Excluding clients with post-traumatic stress disorder (PTSD) stemming from specific horrific experiences at the Pentagon, we could identify only one individual during the post September 11th time frame who requested services specifically to reduce an overwhelming fear of additional terrorist attacks. In this case, a female client had stopped working and was unable to function due to the intensity of her fear that she or her husband would be a victim of a terrorist attack. She understood well that the intensity of her anxiety was substantially higher than levels experienced by others in her community. She did not suffer from OCD but had been diagnosed with generalized anxiety disorder (GAD). Before treatment could get underway, she abruptly moved out-of-state because her anxiety was so intolerable.

Impact of Terrorism on BTC Clients Suffering from OCD

Clinician reports on the impact of terrorism were highly consistent; all clinicians reported no more than a handful of specific cases in which their client's OCD worsened. The clinicians as a group estimated that over 95% of OCD clients responded to the terrorist attacks and threats much like the general public, regardless of the client's age. They were concerned about the events and expressed heightened levels of anxiety; however, the levels did not strike the clinicians as notably higher than those in the general public. A few individuals did report worsening symptoms. For example, there was an unfortunate coincidence associated with the September 11th attack; a female client had been undergoing exposure treatment to the theme that she could "will" catastrophic events such as war, death, and terrorist attacks by thinking them. She had been practicing having such thoughts at the time of the attack on the World Trade Center and the Pentagon. Predictably, her OCD worsened. Despite this setback, she ultimately did overcome her fears and improve substantially. Other cases in which OCD symptoms worsened tended to involve intensified fears of harm coming to the client or others as a result of the threat of terrorism.

Contrary to expectations, OCD did not worsen in the majority of clients. Likewise, very few clients reported worsening OCD due to the addition of new terrorist-related obsessional themes. In a few cases, clients who had other forms of contamination fears did become exceedingly fearful of anthrax contamination. However, these were the exceptions. Most clients seemed to handle the additional anxiety in stride as did the rest of us. No clients reported an improvement in symptoms as a result of being distracted by terrorist fears. However, a few clients did report feeling a greater kinship with others in the community as a result of terrorism, because they felt others were experiencing the elevated levels of anxiety and apprehension that were all too familiar experiences in their lives.

So far, it seems that terrorism succeeds in heightening fears in the general public, precipitating psychological disorders in some people and exacerbating existing symptoms in a minority of persons with existing disorders. Terrorism has not produced a notable increase in requests for services, at least as far as our clinical practice is concerned. Clinical practices in other areas of the country, such as, New York, may report a substantially greater impact from terrorism. The effects of terrorism on clients with psychological disorders are likely to vary greatly depending on location and clinical diagnosis. It may be that clients with GAD who live in New York City responded differently than our OCD clients in the Washington, D.C. area. Certainly the symptoms of PTSD experienced by large numbers of New Yorkers as a result of the events of September 11th remind us of the terrible toll terrorism can take on ordinary citizens. With regard to OCD, however, our general impressions suggest that the impact of terrorism on our clients is more subtle in the vast majority of cases, while a small percentage sustains more devastating blows.

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