OCF Obsessive Compulsive Foundation

OCD Newsletter

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OCF GRANTS EIGHT RESEARCH AWARDS FOR 2007

Research is the basis to understanding and treating OCD and OCD spectrum disorders. Now in its 14th year, the Obsessive Compulsive Foundation, Inc. research awards program allows investigators to conduct research for diagnosis and treatment options for people with OCD. The Review Committee of the OCF's Scientific Advisory Board evaluated an impressive list of compelling proposals. The winning proposals ranged from identifying OCD in young children to studying the brain activity of people with BDD (Body Dysmorphic Disorder). Two of the winning proposals were submitted by Ph.D. candidates, whom reviewers regard as promising researchers in the field of OCD and OCD spectrum disorders. This year, $290,485 was granted to researchers, thanks to donations to the Obsessive Compulsive Foundation Research Fund.

Research proposals were reviewed by a committee composed of members of the OCF Scientific Advisory Board (SAB) and other OCD experts, with final decisions made by Obsessive Compulsive Foundation, Inc. board members. According to Joy Kant, President of the Obsessive Compulsive Foundation, Inc. Board of Directors, "[t]he range of research programs chosen this year should help to expand our knowledge of OCD in a variety of areas. It provides a promise of real progress." Patricia Perkins, J.D., Executive Director of the OC Foundation, is pleased that through the contributions of its members and friends, the OCF will be funding very important research with its 2007 OCF Research Awards.

The awards given out this year were from $10,000 to $49,750. The following are descriptions of the 2007 awardees topics:

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Riluzole May Improve Symptoms in Children with Treatment-Resistant Obsessive Compulsive Disorder

By Paul Grant, MD
National Institute of Mental Health
Bethesda, MD

Recently, our research team completed a trial of a novel medication treatment, riluzole, for children and adolescents with moderate to severe Obsessive-Compulsive Disorder. Six patients, ages 8-16, took part in the 12-week open-label study at the National Institute of Mental Health of the National Institutes of Health in Bethesda, Maryland.

Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS) scores and Clinical Global Impression - Improvement (CGI) scores were measured at the onset of the study and at each follow-up visit. The improvement in CY-BOCS for all 6 subjects was 38% by the end of the 12 weeks, a considerable and meaningful change. (Two patients showed little or no improvement during the study period, but their symptoms did not worsen while taking riluzole). Four of the six subjects had clinically meaningful improvements, which were sustained at follow-up visits. The children reported being "much" or "very much" improved while taking riluzole One of these patients was taking 3 other psychiatric medicines at the start of study and elected to stop those medications and continue only riluzole after completing the study; he continues to do

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MESSAGE FROM THE PRESIDENT

Dear Friends,

The 14th Annual Obsessive Compulsive Foundation Conference is taking place at the Woodlands Waterway Marriott Hotel & Convention Center in The Woodlands, Texas (near Houston) on July 19-22, 2007. By the time you receive this newsletter, it will be less than a month away. If you have not made plans to attend, we encourage you to register online at www.ocfoundation.org. Or, if you want to chat with a staff member at the Obsessive Compulsive Foundation about attending the conference, please call 203-401-2070.

On Thursday afternoon, we will be offering for professionals an Advanced Behavioral Institute (BTI). Space is limited. Interested professionals can register online or call the Foundation for additional information. The Foundation has a flyer that is available for your perusal.

This year, Linda McIngvale, a member of the OCF Board of Directors, has volunteered to implement a new segment during the conference. On Friday, July 20 from 9 am until 2 pm, there will be a sem-

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DON'T MISS THE 14TH ANNUAL OCF CONFERENCE – REGISTER ONLINE NOW

Bulletin Board

Wanted: Anxiety Specialist

Located in beautiful San Luis Obispo, California, the Coastal Center for Anxiety Treatment, a growing private practice, is seeking a clinician to provide CBT for a range of anxiety and obsessive-compulsive spectrum disorders. Competitive fee-for-service reimbursement with growth potential. Post-license preferred. Contact Dr. Eric Goodman by phone at (805) 473-3388 or fax CV and cover letter to (805) 548-0815.

Study of Perception in BDD and OCD

Dr. Fugen Neziroglu and Dr. Yaryura-Tobias at the Bio-Behavioral Institute in Great Neck, NY, are studying differences in perception between people with Obsessive-Compulsive Disorder, Body Dysmorphic Disorder, and healthy controls, especially with regard to appearance related perception. Greater understanding of perception in these populations could aid in designing therapies that better target the factors that contribute to the disorders. Participation is open to anyone with OCD or BDD, or without any psychiatric diagnosis. Participants need to allow us to photograph them. Participants receive feedback as well as compensation.

Information:

The study will begin in June/July. The Bio-Behavioral Institute is located in Great Neck on Long Island, NY. For more information or to sign up, call and speak with Natalie or Jonathan at (516) 487-7116.

Information is also available on our website: http://www.bio-behavioral.com/home.asp

Internship Available CSW/MHC

The OCD Resource Center of Florida, a private practice specializing in the comprehensive treatment of the obsessive-compulsive spectrum and anxiety disorders, seeks qualified registered interns to treat adults and children with neurobehavioral disorders. This is a paid internship based in our Hollywood office that offers exceptional training and supervision in the use of the cognitive-behavioral treatment model for adults and children with anxiety disorders, primarily the obsessive-compulsive spectrum. Treatment responsibilities include individual and group cognitive-behavior therapy. This is not an eclectic internship, but rather an experience best suited to a candidate interested in building specialized treatment skills in the cognitive-behavioral treatment of anxiety disorders.

For more information, email your resume or CV plus a cover letter describing your interest to:

Bruce M. Hyman, Ph.D., LCSW, Director
OCD Resource Center of Florida
3475 Sheridan St., Suite 310
Hollywood, Florida 33021
www.ocdhope.com
ocdhope@bellsouth.net
Phone 954-962-6662, Ext. 2

Obsessive-Compulsive Disorder Study for Children and Adolescents

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

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

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

National Institute of Mental Health, National Institutes of Health, Department of Health and Human Services

Appearance Concerns Medication Research Study

Are you worried about the way any part(s) of your body (for example, your skin, hair, nose, eyes) look?

Do you think about your appearance for more than one hour per day?

Do these thoughts upset you?

Do you have problems with your school, family, or friends because of your worries?

Do you wish you could do something about this problem?

IF YOU ARE A CHILD OR TEENAGER (age 16 and younger) and answered "yes" to any of these questions, you might be eligible to participate in a study at Massachusetts General Hospital (MGH). If you qualify, you will receive the following:

Diagnostic Evaluation
Study Medication

You will also be asked to fill out some questionnaires assessing body image symptoms, anxiety and mood. Participation in the study will be at no cost to you.
If you are interested in participating, or would like to get further information, please call the Body Dysmorphic Disorder Clinic at Massachusetts General Hospital at (617) 643-3079 or email BDD@partners.org.

Research Volunteers Needed!

Have you been diagnosed with Obsessive-Compulsive Disorder?

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

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OCD NEWSLETTER

The OCD Newsletter is published six times a year.

Obsessive Compulsive Foundation, Inc.
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Joy Kant, President,
Board of Directors
Patricia B. Perkins, J.D.,
Executive Director/Newsletter Editor
Michael Jenike, M.D., Chairperson,
OCF Scientific Advisory Board

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

Make Your Plans Now to Come to the 14th Annual OCF Conference

July 19-22, 2007

at

The Woodlands Waterway Marriott Hotel & Convention Center The Woodlands, Texas

- There will be Workshops, Presentations and Support Groups led by some of the best clinicians and investigators in the area of OCD.
- This Conference is specifically designed for People with OCD, Family Members, Children, Adolescents and Young Adults with OCD and Treatment Providers.

For more information or to request a Registration Brochure, call 203-401-2070, ext. 11
You can also register online at www.ocfoundation org.

Helping the Helpers: Roadmap to Recovery

Chad Wetterneck, MA; John Hart, LCPC; & Thröstur Björgvinsson, Ph.D.
Menninger OCD Treatment Program
The Menninger Clinic
Houston, Texas

The Menninger Clinic OCD Treatment Program recognizes the difficulties and struggles sufferers and their families encounter when dealing with severe OCD. Our sufferers typically have been living with overwhelming fears and time-consuming rituals for many years before arriving at the treatment center. Most sufferers and families have also worked with a number of outpatient therapists and psychiatrists, trying numerous medication trials and a variety of therapies. The frustration that comes from living with the disorder not only affects the person living with OCD, it also impacts the caregivers and family members.

When sufferers first arrive at our clinic, it is common to see them without any hope, consumed by obsessions and compulsions. We also often see the caregivers and family members of the OCD sufferer experiencing similar feelings of hopelessness and exasperation. The nature of OCD symptoms leaves no family untouched, since the rituals usually influence family interactions in various ways. The natural tendency for a family member is to soothe a loved one when they are in distress. What we know about OCD is that the accommodation of symptoms may work in the short-term but often will inadvertently reinforce OCD symptoms. Therefore, we try to include caregivers and family members in the treatment process to help reduce the OCD symptoms and to address the strong feelings that are often experienced. This article will help to identify the impact on caregivers and give direction as to how they can begin to cope with the feelings of stress and burden associated with the care they give.

The Experience of Burden in Caring for Those with Mental Health Disorders

It is with some reluctance that we use the term "burden" to describe the negative feelings associated with caring for someone with a mental health concern. We realize that individuals with OCD did not choose to have the disorder, nor do we think caregivers take on more accountability solely out of obligation. We define care-giving as assuming extra responsibilities associated with the onset of a mental health concern. We believe that most of these responsibilities are performed out of love and concern, even necessity, for someone the caregiver cares deeply about.

Many times the onset of OCD, regardless if it is in childhood or adulthood, changes the dynamics of the relationship so that caring often appears to be one-sided. As symptoms of OCD worsen, some sufferers become intensely focused on their fears and may require more assistance from caregivers, thus creating a discrepancy in attention in the relationship.

Researchers have tried to categorize the types of burden experienced by caregivers as either objective or subjective. Objective burden refers to variables that one can measure, such as the financial costs of treating the illness, lost wages, time spent in caretaking activities, and a reduction in the time spent with friends or other family members. Subjective burden involves how the difficulties of caretaking influence the thoughts and feelings of caretakers. Examples include elevated levels of stress, frustration, hopelessness, guilt, or worry. Although there have been attempts to make a distinction between these types of burden, it appears as though the two areas are highly correlated (i.e., the level of subjective burden is related to the level of objective burden).

Kuipers and Bebbington (2005) have outlined a number of factors that seem to play a role in the experience of burden. They include the type and severity of symptoms, the beliefs about the disorder, the coping skills of the caretaker, and the availability of social support networks. For caregivers the misunderstanding or misinformation about the nature of OCD, including blaming oneself or the sufferer for the disorder, expecting the disorder will spontaneously remit, or assuming that the sufferer can no longer have any responsibilities, may increase the feeling of burden. Most people experience some level of shock or confusion when encountering the symptoms of OCD or when they learn about the diagnosis of OCD. Having limited resources and ability to cope with the onset and progression of OCD will also influence the experience of a caregiver's burden. One route to enhance coping is involvement in a social support network. As the sufferer's symptoms progress, many people become more isolated from friends and activities they used to enjoy. Increasing the amount of professional or social support is likely to help to reduce the feelings of burden.

Specific Burden Associated with OCD

There are a number of areas that have been identified as sources of burden, specifically for those who are caretakers for individuals with OCD. OCD expert, Gail Steketee (1997), provided a review of both objective and subjective sources of burden.

Objective burden included: unemployment or financial costs of treatment; reduction in social activities and loss of friendships; reduction in housework and grooming; neglect of children; increase in arguing; and accommodation of rituals. Areas of subjective burden were: feeling responsible for the sufferer's difficulties; feeling manipulated; difficulty managing anger; grief about the loss of functioning; neglect of the caretaker; and depression and worry about the future.

In line with the findings of Dr. Steketee, a retrospective study of our adult sufferers over a 7-month period at Menninger Clinic OCD Treatment Program confirms many of these difficulties (Wetterneck, Hart, Heffelfinger, & Björgvinsson, 2007). Approximately 81% of adults lived at home with family despite only 14% of them being married. Although most were unemployed (86%), many required help with daily living tasks such as grooming and cleaning (62%). In addition, most sufferers (75%) reported a significant disruption in social activities, and many (77%) indicated the cost of treatment and the loss of wages were a significant financial burden on the family.

Reducing Burden: A Roadmap to Recovery

In the beginning, families with an OCD sufferer are functioning in the survival mode. Their motivation is to just get through another day while stamping out one OCD fire after another. This mode often leads to confusion, resentment, and pessimism. Typically there is no sense of direction. Mapping where the sufferer and caregiver are in the recovery process can be very useful in reducing conflict and increasing optimism.

It would be too simplistic to state that the best way to deal with burden is to get treatment for the individual with OCD. Given the chronic course of the illness and the fact that not everyone responds well to treatment, there must be other alternatives to reduce burden. Comprehensive evi-

dence based treatment is crucial and will likely reduce OCD symptoms; however, other activities are important to reduce the caregiver's burden. These include education about the disorder, assessing and re-evaluating beliefs about the disorder and its symptoms, increasing coping skills and social support, and engaging the family in treatment. Such steps can help to reduce the experience of burden and may actually enhance treatment outcomes.

Education about OCD is essential in addressing burden. Despite the effectiveness of treatment for some individuals, obsessive thoughts may never fully disappear. Even those people who reduce the impact of OCD in their lives still struggle with OCD triggers and resisting rituals. Therefore, expecting a total remission may be unrealistic, and disappointment associated with this realization may increase the sense of burden. Gary Geffken and colleagues (2006) noted that establishing realistic hopefulness may be helpful to family members struggling with negative emotions while coping with their family member's OCD.

A number of beliefs or appraisals are commonly expressed by the caregivers of sufferers that may contribute to burden. One such example is the attribution of responsibility to the OCD sufferers about their ability to control their symptoms. Given the irrational nature of some OCD fears, many caregivers feel that sufferers should have greater control over their avoidances and ritualizing. This type of attribution seems linked to some of the concepts of high expressed emotion (mainly criticism or hostility), which has been found to be correlated with poor anxiety treatment outcome and increased likelihood of treatment dropout (Chambless & Steketee, 1999).

Although often challenging, caregivers must learn to accept the sufferer's OCD fears and irrational thoughts as part of OCD and nothing more. This often requires the caregivers to overcome their own fears about the loved one in a way similar to how the loved one is asked to overcome his or her OCD fears when undergoing behavioral treatment. This approach may not only reduce caregivers' feelings of burden, but research also indicates that less anxious (i.e., firm, non-reactive) family members are more successful providing support and supervision in treatment than anxious, inconsistent ones (see Steketee & Van Noppen, 2003).

Understanding the role of undesirable accommodations is also essential for both improving treatment and reducing burden. Accommodation includes a number of activities such as: participating directly in rituals/compulsions; facilitating avoidance by insulating the loved one from triggers in the environment; taking over the responsibilities of the loved one; repeatedly answering questions for reassurance; and changing "normal" family routines. Accommodation serves to reinforce and maintain OCD behaviors. While most family members report accommodating symptoms, it has been linked to global family disruption and distress (Calvocoressi et al., 1995). Thus, the act of trying to help may lead to increased symptoms and increased burden while paradoxically making the disorder worse over time. Unfortunately, when caregivers become aware of the role of accommodation in the maintenance of OCD, there is often an accompanying sense of guilt and responsibility. This is where a road map can be useful. Efforts to abruptly end accommodating behavior usually result in frustration and disappointment. An organized plan, that includes a hierarchy of accommodating behavior, can foster some early and often badly needed successes on the way to recovery.

John March and Karen Mulle (1998) introduced the concept of mapping in their treatment of children and adolescents. We have adapted that concept to incorporate the role of the family in treatment. In mapping, specific OCD symptoms will be identified as targets in treatment that both caregivers and the sufferer agree to work on. Caregivers note the symptoms that they will no longer accommodate and make a gradual and systematic plan for disengagement. This plan will allow for the sufferer to challenge a fear by taking on more responsibility and will relieve the caregiver from an additional duty. It also provides a planned approach that gives direction to caregivers and sufferers and helps relieve the burden of care-giving by reducing the expectation that accommodations should be eliminated all at once. Inevitable concessions to active OCD symptoms are more tolerable when caregivers know what is being worked on and what is going to be worked on in the future.

Another essential key to reducing burden is developing a social support network. This may include re-establishing ties with friends or family members that were lost as the illness seemed to take over the family. Support can also be found through treatment providers and other people dealing with a loved one afflicted with OCD. There may not be existing support groups in your area, but starting one may help you and many others. The internet has become a huge source of information and support for many individuals. Support groups can occur online, and one could benefit simply by posting a concern or expressing themselves on a message board and returning later to see replies of advice and encouragement.

There may be a number of caregivers who experience difficulty with getting their loved one into treatment (e.g., due to being unwilling or unable to attend therapy), or find that their loved one does not respond to treatment. In these cases, we must still try to "think outside the box" in order to reduce burden. If the sufferer is not willing to go to treatment, then the caregivers should go themselves to learn how to manage their own lives and cope with their own feelings, while still encouraging the afflicted person to enter treatment.

The Importance of Self-Care

Evidence from research has indicated that those living with a family member with a mental illness had poorer perceptions of their own health (Walton-Moss, Gerson, & Rose, 2005). Family members with mentally ill relatives reported more activity limitations, hospitalizations, and more physician visits. It is very important that caregivers focus on their own self-care; this includes both their physical and mental well-being.

It is beneficial that positive family activities that have been set aside due to the struggles with OCD be resumed. Avoidance of worthwhile and necessary activities can directly lead to burnout and depression. Exercise schedules or hobbies that were given up can be returned to as a way of coping. Many caregivers are frustrated with this advice and wonder where they are going to get the time and energy to engage in these activities. Caregivers often give up these activities because they have followed the path of least resistance by finding it easier to stay home or ignore their own needs rather than fight the sufferer's OCD symptoms. The fears that caregivers have, that something catastrophic will occur if they tend to their own needs, is understandable given what many families have been through. No doubt sufferers will struggle more when a caregiver goes away for a weekend or even a few hours in some cases. Allowing a sufferer to struggle on his/her own is part of the recovery process. Recovery is often "painful progress" for both caregiver

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Research Dig

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

Best practice in treating obsessive-compulsive disorder: what the evidence says

H.B. Simpson and M.R. Liebowitz. In: Rothbaum BO (ed), Pathological Anxiety: Emotional Processing in Etiology and Treatment, Guilford Press: New York, 132-146, 2006

For more than 10 years, the Center for the Treatment and Study of Anxiety, directed by Edna Foa at the University of Pennsylvania in Philadelphia, and the Anxiety Disorders Clinic, directed by Michael Liebowitz at Columbia University in New York, have worked together in researching how best to treat OCD. Their research and key findings are presented in this book chapter. Findings include:

1. Behavior therapy, using exposure and ritual prevention, and medication treatment, using serotonin reuptake inhibitors (SRIs), are both effective treatments for adults with OCD.

2. Behavior therapy can be superior to SRI treatment when delivered intensively by skilled therapists.

3. Behavior therapy can be more durable than SRI treatment.

4. Many SRI responders continue to have clinically significant OCD symptoms and require additional treatment.

5. Behavior therapy may be one of the safest and most effective ways to augment a partial SRI response.

6. Even with use of these treatments, many OCD patients continue to have impaired functioning and poor quality of life.

The chapter concludes by discussing advantages and disadvantages of both treatments. A main advantage of SRIs is easy availability and with the exception of clomipramine (Anafranil), these medications have minimal side effects and few that are dangerous. Disadvantages of SRIs include the facts that a high percentage of patients do not respond and relapse is likely when medications are discontinued. Advantages of behavior therapy include that it can be more effective than SRIs if delivered by skilled therapists and it results in lower relapse rates after discontinuation of active treatment. Limitations of behavior therapy include it not being widely available, not all patients maintain their gains long term, and some patients refuse, drop out of, or only partially follow treatment.

Cognitive behavior therapy and paroxetine in the treatment of hypochondriasis: a randomized controlled trial

American Journal of Psychiatry, 164:91-99, 2007, A. Greeven, A.J.L.M. van Balkom, S. Visser et al.

Hypochondriasis is a disorder in which individuals have persistent, irrational fears or beliefs that they have a serious, undiagnosed medical illness. Similar to OCD, hypochondriasis involves obsessions and compulsions-obsessions about being ill and compulsions to check with others for either diagnosis and treatment or reassurance that one is not ill. Researchers randomly assigned 112 subjects with hypochondriasis to 16 weeks of treatment with cognitive-behavioral therapy (CBT), paroxetine (Paxil) or placebo. Diagnosis and treatment took place at three psychiatric outpatient clinics in the Netherlands. Both CBT and paroxetine treatment were significantly superior to placebo, but on most measures did not differ significantly from each other. Researchers concluded that both CBT and paroxetine were effective short-term treatment options. After these treatments, patients were less preoccupied with their fears of having a serious disease and also had fewer associated depressive and anxiety symptoms.

Paroxetine treatment of compulsive hoarding

Journal of Psychiatric Research, 41:481-487, 2007, S. Saxena, A.L. Brody, K.M. Maidment et al.

Compulsive hoarding and saving symptoms, defined as the acquisition of and inability to discard worthless items, are found in 18-42% of OCD patients. Some studies have found that hoarding and saving symptoms were associated with a poor response to treatment. Here the response to paroxetine (Paxil), a serotonin reuptake inhibitor (SRI), was compared between OCD patients with hoarding symptoms (n=32) and OCD patients without hoarding symptoms (n=47). Both compulsive hoarders and non-hoarding OCD patients improved significantly with treatment. There were no significant differences between groups in terms of the number of patients completing or responding to treatment. Hoarding symptoms improved as much as other OCD symptoms. Results of this study suggest that SRIs may be as effective for compulsive hoarders as they are for non-hoarding OCD patients.

Postpartum-onset obsessive-compulsive disorder: incidence, clinical features, and related factors

Journal of Clinical Psychiatry, 68:132-138, 2007, F. Uguz, C. Akman, N. Kaya et al.

This study investigated the incidence rate, symptoms and factors associated with postpartum-onset OCD. After excluding women with OCD, subclinical OCD or depression, 302 women were interviewed on the first day after childbirth and 6 weeks later. Twelve of these women (4%) were diagnosed with OCD and for 3 of these women the OCD onset occurred following a second childbirth. No association was found between OCD and the type of delivery or complications during pregnancy. OCD symptoms began within the first 2 weeks after childbirth for 7 women and at 2 to 4 weeks for the other 5 women. These 12 women were compared to a control group of 33 women with OCD without a postpartum onset. Women with postpartum onset OCD had significantly more frequent aggression obsessions and less severe obsessive-compulsive symptoms. Additionally, women with postpartum onset OCD had significantly higher rates of avoidant personality disorder and obsessive-compulsive personality disorders, suggesting these personality disorders may be risk factors for the development of new-onset OCD by negatively influencing new mothers' ability to cope with intrusive thoughts after childbirth.

An association of intrusive, repetitive phrases with lamotrigine treatment in bipolar II disorder

CNS Spectrums, 12:106-111, 2007, D.E. Kemp, W.S. Gilmer, J. Fleck et al.

OCD can occur with bipolar disorder. This report is unique in that the intrusive thoughts appear to be caused by a medication. Lamotrigine (Lamictal) is an anticonvulsant medication approved for the treatment of bipolar disorder. Case reports are presented of five patients with

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bipolar disorder who reported obsessions characterized by intrusive repetitive phrases, musical melodies, and numerical repetitions. Recurrent phrases consisted of song lyrics, senseless statements (such as "I'm going to dinner tonight" over and over again), and number repetitions (such as phone numbers). Unlike obsessions in OCD, the intrusive phrases were not accompanied by anxiety or used to neutralize distressing thoughts. Obsessions occurred from 7 to 42 years after mood disorder onset, occurred only after initiation of lamotrigine treatment, and disappeared with lamotrigine discontinuation or dose reduction and recurred with lamotrigine re-challenge or dose increases. It is hypothesized that by altering brain glutamate levels, lamotrigine at higher dosage may induce intrusive, recurrent phrases.

Antipsychotic augmentation of serotonergic antidepressants in treatment-resistant obsessive-compulsive disorder: a meta-analysis of the randomized controlled trials

European Neuropsychopharmacology, 17:79-93, 2007, P. Skapinakis, T. Papatheodorou and V. Mavreas

Authors evaluated the effectiveness of antipsychotic augmentation of serotonin reuptake inhibitors (SRIs) for treatment-resistant OCD by carrying out a meta-analysis of all randomized controlled trials. Meta-analysis is a mathematical process of combining and comparing research results from previous separate but related studies. Ten studies were compared–1 augmenting with haloperidol (Haldol), 3 augmenting with risperidone (Risperidal), 2 augmenting with olanzapine (Zyprexa) and 4 augmenting with quetiapine (Seroquel). A total of 157 patients were randomized to a study drug and 148 were randomized to placebo. The overall response rates were 46% for the antipsychotic augmentation group and 16% for the placebo augmentation group. This meta-analysis supports the effectiveness of antipsychotic drugs as an augmentation strategy.

Quetiapine addition in obsessive-compulsive disorder: is treatment outcome affected by type and dose of serotonin reuptake inhibitors?

Biological Psychiatry, 61:412-414, 2007, D. Denys, N. Fineberg, P.D. Carey et al.

If OCD does not improve with serotonin reuptake inhibitor (SRI) treatment, there is evidence that addition of an atypical antipsychotic to the SRI may improve treatment response. Researchers assessed the effect of type and dose of SRIs on treatment outcome in quetiapine addition trials for OCD. Data from several controlled studies of quetiapine (Seroquel) addition to SRIs were pooled. Treatment outcome was evaluated by change in the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) scores. With treatment response defined as a 50% Y-BOCS decrease, 18 patients (17.6%) of 102 patients in the collected sample responded to the addition of quetiapine. The best response was reported with quetiapine combined with clomipramine (Anafranil), fluoxetine (Prozac), and fluvoxamine (Luvox). Interestingly, better responses occurred with lower SRI doses. Caution was recommended in interpreting results because sample sizes were small and the original studies were not designed to compare dose or type of SRI.

An autistic dimension: a proposed subtype of obsessive-compulsive disorder

Autism, 11:101-110, 2007, S. Bejerot

Autism spectrum disorder (Asperger's syndrome, autism and atypical autism) in its milder forms may be clinically important for many patients with OCD. Features of autism spectrum disorder (ASD) are markedly abnormal or impaired development in social interaction and communication, and a restricted range of interests and activities. Repetitive routines and rituals are frequent in ASD, as well as is hoarding. Dr. Bejerot proposes OCD with comorbid ASD is a subtype of OCD. Part of her theory is that obsessive-compulsive and schizotypal personality disorders are often seen in OCD and these may actually be clinical manifestations of ASD. Also, OCD is more common than expected among relatives of individuals with autism. Dr. Bejerot suggests that when ASD occurs with OCD, the OCD is often more severe and treatment resistant. An odd personality, with paranoid, schizotypal, avoidant or obsessive-compulsive traits, may indicate autistic dimensions in OCD patients. OCD patients with autistic traits will need additional approaches to improve social functioning.

RILUZOLE MAY IMPROVE SYMPTOMS IN CHILDREN

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very well. Two other patients are virtually free of OCD symptoms, taking only riluzole. A fourth responder is not as dramatically improved, but has stopped other medicines (which had apparently not been helpful).

All patients were allowed to continue their current medications, and riluzole was added in 10-milligram increments as quickly as tolerated. The patients were encouraged not to change their current medicines during the 12 weeks, and they did not engage in exposure/response prevention therapy (or cognitive-behavioral therapy) during the 12 weeks.

Our patients were monitored carefully by in-person visits and laboratory evaluations. None of the patients had serious adverse effects from riluzole.

Riluzole (Rilutek) is a glutamate antagonist and likely acts by reducing the amount of glutamate available in the brain to stimulate nerve cell receptors. Glutamate, the principle excitatory neurotransmitter in the brain, has been associated with nerve cell injury when present in excess. Riluzole currently has Food and Drug Administration approval for treating amyotrophic lateral sclerosis (or Lou Gehrig's disease) in adults. Riluzole has been shown to be effective in a few open-label studies for adults with OCD and with depression. Our study was the first trial of riluzole of which we are aware for any psychiatric symptom in childhood.

Given that significant numbers of young people do not derive benefit from standard medication regimens, the selective serotonin reuptake inhibitors (SSRIs), there is clearly a place for a safe and effective alternative. The outlook seems promising so far for riluzole treatment in childhood OCD. But an open-label trial has obvious limitations. Only a placebo-controlled trial can distinguish drug effects from the non-specific effects of the treatment. We have just opened a double-blind placebo-controlled study of riluzole for childhood OCD and are now enrolling patients (see page 2, Bulletin Board).

Participants will be children and adolescents 7-17 years of age with OCD who have not responded to standard medication treatments. In addition to the children with a primary diagnosis of OCD, this study also will enroll young people with OCD and an autism spectrum disorder such as Asperger Syndrome, pervasive developmental disorder (PDD), or autism. The outcome measures will be changes in CY-BOCS and CGI, but repetitive behaviors (seen in autism spectrum disorders)

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2007 OCF RESEARCH

(continued from page 1)

Jamie Feusner, M.D., Semel Institute for Neuroscience and Human Behavior

Department of Psychiatry and Biobehavioral Sciences, David Geffen School of Medicine, UCLA, Los Angeles, CA

"Visual Information Processing in Body Dysmorphic Disorder"

Dr. Feusner's study seeks to discover whether patients with BDD (Body Dysmorphic Disorder) have different kinds of brain activity than those without BDD. People with BDD are exceedingly critical of their appearance, often believing that they are ugly or hideous. Preliminary research suggests that patients with BDD have unusual ways of processing what they see. The researchers in the present study will use fMRI (functional magnetic resonance imaging) to map the subjects' brain activity when they look at pictures of their faces.

Dr. Jamie Feusner

Dr. Feusner is an Assistant Professor-in-Residence of Psychiatry and Biobehavioral Sciences at the Semel Institute of Neuroscience and Human Behavior, UCLA, and is the Director of the UCLA Obsessive-Compulsive Intensive Treatment Program. Dr. Feusner is also a Psychiatric Consultant for the Los Angeles Body Dysmorphic Disorder Clinic.

John Piacentini, Ph.D., ABPP, Division of Child and Adolescent Psychiatry, Semel Institute for Neuroscience and Human Behavior, UCLA, Los Angeles, CA

"Controlled Evaluation of Positive Family Interaction Therapy (P-FIT) for Children and Adolescents with OCD"

According to Dr. Piacentini, previous research indicates that nearly one-third of children with OCD who received individualized CBT (cognitive-behavior therapy) failed to show improvement. Yet family therapy is a positive addition to individual treatment. Dr. Piacentini's study proposes a family-based approach to children and adolescents with OCD with a family intervention called Positive-Family Interaction Therapy (P-FIT). Dr. Piacentini suggests that P-FIT can "enhance family cohesion by focusing the family's attention on troublesome situations rather than on difficult individuals by creating a positive family atmosphere within the therapy session and at home." Thirty-two youths, ages 9-17, and their families will be recruited for this study.

Dr.John Piacentini

Dr. Piacentini is a Professor of Psychiatry and Biobehavioral Sciences, Director, Child OCD, Anxiety and Tic Disorders Program, and Chief Child Psychologist, Medical Psychology Program, at the Semel Institute for Neuroscience and Human Behavior, UCLA.

Rene Staskal, Department of Counseling, Clinical, and School Psychology, University of California at Santa Barbara, Santa Barbara, CA

"Cross-Cultural Issues in Assessment and Identification of Obsessive Compulsive Disorder in the Public School Setting"

Ms. Staskal's study seeks to "increase methods of early identification and treatment of OCD in the school setting." According to Ms. Staskal's proposal, schools are the best places to identify mental illnesses in children. However, the identification of mental illness in students who are racial minorities has not been the subject of research. Ms. Staskal's study has three goals: 1. to examine how students with OCD are identified and treated by school psychologists; 2. to examine whether Asian, Latino, and white students are treated equally for OCD symptoms in school settings; and 3. to examine whether the Yale-Brown Obsessive Compulsive Scale (YBOCS) is the best assessment tool for identifying OCD in Asian and Latino students. Ms. Staskal notes that the third goal is of particular importance "because school-based programs and assessment measures need to demonstrate cultural sensitivity."

Rene Stakal

Ms. Staskal is a doctoral candidate in Counseling, Clinical, and School Psychology at the University of California at Santa Barbara. She is also a Graduate Student Therapist at the Koegel Autism Clinic at the University of California at Santa Barbara.

Golda Ginsburg, Ph. D., Division of Child and Adolescent Psychiatry, Johns Hopkins University School of Medicine, Baltimore, MD

"Psychosocial Treatment of Obsessive Compulsive Disorder in Young Children"

Dr. Ginsburg's study will use a "parent-focused, CBT-based intervention" for children ages 4 to 7. Their parents will also participate in the study in the hopes of limiting the ways in which parents accommodate OCD in their children. Children as young as 2 have exhibited symptoms of OCD. Yet, there has not been a research study that assessed the use of CBT (cognitive-behavior therapy) and medications in children younger than age 7. Ginsburg said that "this is the first time that an intervention has been developed and systematically evaluated for this challenging but largely ignored clinical population."

Dr. Golda Ginsburg

Dr. Ginsburg is an Associate Professor in the Department of Psychiatry and Behavioral Sciences and in the Division of Child and Adolescent Psychiatry at the Johns Hopkins University School of Medicine. Dr. Ginsburg is also the Director of Pediatric Psychology and

AWARD RECIPIENTS

Anxiety/OCD Clinic at the Johns Hopkins University School of Medicine.

Arthur A. Simen, M.D., Ph.D., Department of Psychiatry, Yale School of Medicine, New Haven, CT

"Genomic Copy Number Variation in Obsessive Compulsive Disorder"

Dr. Simen's study seeks to determine the number of copies of each segment of the human genome in patients with OCD compared to unaffected individuals.

Dr. Arthur A. Simen

There are genetic factors associated with risk for OCD but identifying the responsible genes has been difficult. According to Dr. Simen, individuals normally have two copies of each segment of the genome, one from the father and one from the mother. Scientists have recently discovered that humans frequently have more or less than the expected number of copies of certain regions in their genomes also known as copy number variants (CNVs) and CNVs "are common but their role in psychiatric disease is unknown." In the first phase of the study, 15 patients without OCD and 15 patients with severe OCD will be compared to identify CNVs of potential relevance for OCD. In the second phase, the CNVs identified in phase one will be assessed in larger groups of individuals with and without OCD.

Dr. Simen is an Assistant Professor of Psychiatry at the Yale School of Medicine.

Kiara R. Cromer, M.S., Department of Psychology, Florida State University, Tallahassee, FL

"A Prevention Program for Postpartum OC Symptoms"

Ms. Cromer's research proposes to develop and execute "a prevention program for postpartum obsessive-compulsive (OC) symptoms." OCD is one of the most prevalent postpartum anxiety disorders; and up to 40% of the females with OCD report symptom onset during perinatal and postpartum periods. During Ms. Cromer's study, women identified as at risk for OCD will be taught cognitive behavior therapy (CBT) techniques, incorporated into prenatal education classes. Ms. Cromer predicts that "this program will improve the general functioning of the mother as well as produce better outcomes for the baby."

Kiara R. Cromer

Eighty women in their second or third trimester of pregnancy will be recruited from Chapel Hill, NC and Tallahassee, FL. Ms. Cromer believes that the research findings will have broad significance, not only from the prevention perspective, but also with regard to our overall understanding of the origins of OCD, since the research communities are ethnically and socio-economically diverse.

Ms. Cromer is a doctoral candidate and Research Fellow in Clinical Psychology at Florida State University and the associate director of the Anxiety and Behavioral Health Clinic

Jordana R. Muroff, M.S.W., Ph.D., Boston University School of Social Work, Boston, MA

"Delivery of Internet Treatment for Compulsive Hoarding (D.I.T.C.H.)"

Dr. Muroff's study will assess the use of an "online CBT-based group intervention designed to help people with compulsive hoarding better manage their symptoms." Compulsive hoarding can include difficulty throwing away items and living among excessive clutter. According to Dr. Muroff, compulsive hoarding requires novel approaches to therapy. The internet is a promising tool for people seeking information about health issues and could be an intervention resource for compulsive hoarders.

Dr. Jordana R. Muroff

The researchers will recruit adult members of an existing online support group that is designed for people who are compulsive hoarders. Participants will be asked to complete four "voluntary anonymous web-based survey[s] designed for this study" over a 12 month period.

Dr. Muroff is an Assistant Professor at the Boston University School of Social Work.

Jonathan Abramowitz, Ph.D., Department of Psychology, University of North Carolina at Chapel Hill, Chapel Hill, NC

"Enhanced Cognitive Behavior Therapy for OCD: A Couple-Based Approach (2 year study)"

Dr. Abramowitz proposes a pilot study to examine the value of involving spouses and partners in the treatment of OCD. Previous research shows that it is common for spouses and partners to accommodate OCD symptoms, which often results in the continuation-not lessening-of OCD. The study will examine CBT (cognitive behavior therapy) for OCD behavior that is part of "an established cognitive-behavioral couples therapy" in the hopes of teaching couples healthy ways of responding to OCD. Study participants must attend 12 therapy sessions twice a week as a couple. Abramowitz adds that this method is suitable for patients in committed relationships.

Dr. Jonathan Abramowitz

Dr. Abramowitz is an Associate Professor in the Department of Psychology at University of North Carolina at Chapel Hill, where he is also the Director of the OCD/Anxiety Disorder Treatment and Research Program.

Help Support Research. Contribute to the OCF Research Fund.

Message From the President

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inar for educators, school psychologists, head counselors and nurses from Texas led by Dr. Aureen Wagner, a clinical child psychologist and an expert in treating anxiety. She is a Clinical Associate Professor of Neurology at the University of Rochester School of Medicine, a member of the Obsessive Compulsive Foundation Scientific Advisory Board, and a Director of the OCD and Anxiety Consultancy in Rochester, New York. This seminar is designed to raise an awareness of Obsessive Compulsive Disorder, how to recognize the symptoms, how to work with students suffering with the illness and how to help them become better students and to function efficiently. Peace of Mind is sponsoring this portion of the conference, a Houston based Foundation that was created by the McIngvales.

In addition to the educators' segment, there will be a workshop for non-psychiatric providers, i.e., general practitioners, pediatricians. It will run from 9 am until 2 pm on Friday, July 20th. The issues discussed will be basic recognition, early intervention, how and to whom providers should refer patients in order that they will receive proper care and medications. There will also be a special section in this session that discusses Obsessive Compulsive Disorder in kids. Diane Davey, a member of the OCF Board of Directors, and Dr. Michael Jenike, Chair of the OCF Scientific Advisory Board, have organized this portion of this conference along with the psychology staff at the OCD Institute at McLean Hospital in Belmont, Massachusetts.

On Saturday morning after my welcoming remarks, the Keynote Address, *Faith, Hope and Inspiration*, will be given by three individuals: Elizabeth McIngvale, the National Spokesperson for the Obsessive Compulsive Foundation and a native of Houston; Julian Swartz, a college student and basketball player; and Jeff Bell, a news anchor for California radio station KCBS and author of *Rewind, Replay, Repeat: A Memoir of Obsessive Compulsive Disorder*.

From Friday until Sunday, there will be approximately ninety-four workshops and nine support groups. One thing we all know, OCD is a family affair. Many of the support groups will focus on families living with OCD and the challenges they face every day. The support groups will be held on the third floor starting Friday evening and continuing throughout Saturday. When you register at the conference, look for the day, the time and the location of the following support groups: G.O.A.L.: Sufferers Empowering Each Other; Young Adult Group: Life Beyond OCD; Siblings' Support Group; "Friday Night Live" Parents' Support Group; Obsessive Compulsive Anonymous; When OCD Invades Your Marriage and or Dating Relationship; Teen Support Group; OCA 12 Step Program for Family and Friends; These Thoughts Are Driving Me Crazy, a support group experience for adults with primarily obsessional OCD. There will also be workshops that provide current research findings and updates. This year the conference program will be labeled to highlight sessions that are geared toward professionals, consumers, families, parents, children and young adults.

If you need a break from the intensity of the conference, walk around the hotel property or explore The Woodlands Town Center that encompasses about two square miles. If you are too tired to walk, ride the air-conditioned water taxi that is docked behind the hotel, six dollars a day for an unlimited number of stops. About a block away from the Woodlands Waterway Marriott Hotel there is Cinemark at Market Street, a movie theater that features a mix of popular titles and independent films. The Cheesecake Factory, P.F. Chang's China Bistro. Starbucks, McDonald's, Jamba Juice, Tommy Bahama's Café and Emporium and Johnny Rockets represent a small sampling of dining choices. In April, I visited the Woodlands Waterway Marriott Hotel and found myself drawn to my favorite hot spot, the Borders Café, where I treated myself to a Cappuccino. For additional information about the Woodlands Town Center, visit their website: www.town-center.com.

I am looking forward to seeing you at the Opening Reception, Welcome To Houston, a reception hosted by the Menninger Clinic, Thursday, July 19, 2007 from 6:30 - 8 pm.

Best Regards,
Joy Kant
President of the Board of Directors of the Obsessive Compulsive Foundation

Helping the Helpers

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and sufferer.

A comprehensive road map includes helping the sufferer begin or return to chores and responsibilities so that the burden can be lifted from the caregiver and promote a sense of mastering and functioning for the sufferer. It is important to state that when OCD is successfully treated the burden eases naturally. When the sufferer struggles in treatment, it is important to remember that the OCD symptoms worked hard to dramatically change the course of the family. So caregivers may have to work just as hard to remain supportive and take back at least part of their lives to reduce the burden.

Correspondence concerning this article should be addressed to Thröstur Björgvinsson, Ph.D., Program Director, Obsessive-Compulsive Disorder Treatment Program, The Menninger Clinic; Associate Professor, Menninger Department of Psychiatry & Behavioral Sciences, Baylor College of Medicine; Menninger OCD Treatment Program; The Menninger Clinic; 2801 Gessner Drive, Houston, TX 77080 Phone: 713 275 5420 e-mail: tbjorgvinsson@menninger.edu http://www.menningerclinic.com/p-ocd.

Riluzole May Improve Symptoms in Children

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will also be measured. Riluzole will be added to current medicines (unless contraindicated) or may be used alone. At the end of 12 weeks, all subjects may elect to take open-label riluzole (no chance of placebo) for the subsequent 3 months. Follow-up visits will be approximately monthly for 6 months, and again at months 9 and 12. There are no costs to the patients to participate in this study at the NIMH, and travel costs may be covered.

In the promising open-label trial just described, the investigators maintained close communication with the patients' own child psychiatrists, who continued to be involved in their patients' care throughout and after the study.

We welcome inquiries and referrals from professionals and from families. Please contact Lorraine Lougee, LCSW-C at (301) 435-6652 or (301) 496-5323; or email OCDNIMH@intra.nimh.nih.gov.

Philosophical Obsessions? Solipsism? How Common Are They? I Never Knew That Is What I Had.

Fugen Neziroglu, Ph.D., ABBP and Estee Acobas, MA
Bio-Behavioral Institute
Great Neck, NY

Robert* at age 30 had a crisis. He had always had various unusual thoughts but did not get diagnosed with OCD until age 20. Since age 11 he had gone to various therapists, but they never seemed to know what he had. Ever since he could remember, Robert obsessed about his health, whether he was breathing properly or not; and then every night he would imagine what it would feel like to be dead. As a child he was afraid to go to bed fearing he would not wake up. He would lay awake wondering if he would stop breathing and how would he know he was not breathing and who could help him. This went on for several years, and then it went away for a while but came back around age 20. It took over his evenings because he feared going to bed knowing he would lay awake for several hours until from pure exhaustion he would fall asleep.

David* was 27 with an IQ of 165 (extremely high); and, many years ago, he hijacked a plane because he wanted to prove that he was alive. He reported a need to hear his name and to have his picture in the papers. He thought that this would be an objective way to prove his existence. He and another patient, Angie,* who was not as radical as David, had one thing in common: an obsession with whether they were alone in this world. Although they could see other people, they believed they were alone on earth. They obsessed about not having a past nor a future.

Very similar to the above cases, Jackie,* who had been obsessing for 20 years before we met her, wondered whether she was alive or dead. Although she could see and talk to other people, she questioned whether she actually was seeing or talking to them. Perhaps others were dead or maybe she was. How could she be certain that she was talking, seeing, feeling. It consumed her day until she had to stop working.

Rick* went in and out of his room repeatedly because he was uncertain whether it was his room. He did not know if he was walking and where his boundaries started and where they ended. He became too fearful to leave his house because he did not know who he became outside of his house, and when he wanted to return home he did not know whether it was his home or not. He questioned every behavior and every movement.

Linda* questioned the purpose of things. Why do I get up? Why do I shower? Is it me who is speaking? What is the purpose of talking, eating? Why do I go to work? Why do people call a cab? The bottom line was the belief that all was useless ultimately; and we were all going to die, or perhaps we were already dead and did not know it. She really did not want the answers to the questions but her thoughts would not stop.

How does one know if s/he is really alive? How does one know if s/he really is where they think they are? Why do we do the things we do? The above cases illustrate examples of patients with OCD who grapple with questions of a philosophical nature. A core feature of philosophy is the absence of an answer to the controversies at hand. In *Problems of Philosophy*, a book written in 1912, Bertrand Russell, discussing the value of philosophy, states that "[p]hilosophy is to be studied, not for the sake of any definite answers to its questions, since no definite answers can, as a rule, be known to be true." He further asserts that once an answer is found to a topic of debate, by definition, the topic ceases to be philosophical in nature, and rather becomes a science.

Epistemology, a branch of philosophy also known as the Theory of Knowledge, is the study of the qualification of knowledge and justification of beliefs. It examines the conditions necessary for a person to know that something is true. Szechtman and Woody (2003) hypothesized that OCD symptoms stem from an epistemic origin. Coining the term 'yedasentience,' which is the sense of the "feeling of knowing," the authors assert that OCD symptoms stem from a lack of this emotion. Similarly, Rapaport (1989) discusses the loss of the ability to qualify knowledge, with patients asking how one knows the answers to questions that most people rarely contemplate, such as; "Is the grass really green? Are my eyes blue?"

Sometimes the debate goes further philosophically, questioning the actual state of existence. The term "solipsism" was first described in 1897 by the British idealist F.H. Bradley. It is a philosophical theory that posits that nothing exists beyond oneself. Existence is defined by experience, and you are the only true participant. Therefore, experiences that occur in your external world only exist through your cognition of them. You are the only person in the world that matters. In *Appearance and Reality,* F. H. Bradley wrote, "I cannot transcend experience, and experience is my experience. From this it follows that nothing beyond myself exists; for what is experience is its (the self's) states."

This model of perceived reality has been seen in people suffering from OCD. The solipsistic view manifests as a belief that the world is only in your head, and only the things that you think about are what exist. If a person believes that he or she does not think or that s/he is not real, then no one else can prove otherwise since nothing exists outside of his or her mind. An obsession develops when an individual relentlessly questions his or her existence, the meaning of that existence, and his or her identity.

This solipsistic angle is somewhat related to dissociation, the psychological experience of a distorted sense of reality that has been found in research to relate to certain forms of OCD. Dissociation is defined in the DSM-IV as the "disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment." Symptoms of dissociation include depersonalization, defined in the DSM-IV as the "persistent or recurrent experiences of feeling detached from, and as if one is an outside observer of one's mental processes or body (e.g., feeling as if one is in a dream, feeling as if one is not real or not alive, or as if one is detached from their body)" and derealization, which is the sense that the external world, or a certain aspect of the external world, such as one's home or one's friend, is unreal. Depersonalization has similar characteristics to OCD, including age of onset and the chronicity of the disorder. In addition, just like OCD sufferers, those suffering from depersonalization focus on a specific theme, which, in the case of depersonalization disorder, is a sense of self and reality. Amnesic dissociation, where one does not retain memory for specific periods or events, has been found to be linked to OCD as well (Rufer, Fricke, Held, Cremer and Hand, 2005). Symptoms of dissociation have been found to be associated with checking symptoms (Grabe, Goldschmidt, Lehmkuhl, Gansicke, et al., 1999; Watson, Wu, Cutshall, 2004; Rufer, et al., 2005), as well as ordering/symmetry (Grabe, et al., 1999) and obsessive intrusions (Watson, et al., 2004).

The nature of this relationship between OCD and dissociation has been discussed in the literature. Grabe, Goldschmidt, Lehmkuhl, Gansicke, et al. (1999) assert that dissociative symptoms result from the intensity of the time and attention demands of rituals. Pica, Beere and Maurer (1997) partially attribute the relationship to rigidity and difficulty in integrating new information from cognitive and perceptual experiences into existing schema. In other words, the association lies in

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**The names have been changed for privacy reasons.*

Philosophical Obsessions

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the difficulty in both dissociation and OCD to make sense of new information and changes in the environment. Watson, Wu and Cutshall (2004) explain the association through the common problems of attention and memory, and they mention that since deficits in these areas would affect checking symptoms more than others, it helps to explain why checking is more strongly associated than some other OCD symptoms. It is not an actual deficit in memory, but rather confidence in one's memory that is low in OCD patients (Tolin, Abramowitz, Brigidi, Amir, Street and Foa, 2001). Merckelbach and Wessel (2000) found that the more dissociation an OCD patient experiences, the lower confidence he holds in his memories. It is worthy to note that Goff, Olin, Jenike, Baer, and Buttolph (1992) found that in some patients reports of dissociation may in fact be a form of their OCD. This applies in particular when dissociative features are experienced solely when engaged in obsessions or compulsions. In these situations, dissociation may function as a way for sufferers to cope with the anxiety attached to a situation.

Mentioned above were two features found to be associated with OCD, namely yedasentience, which is a lack of the feeling of knowing and a lack of confidence in memories. Both of these features appear to feed into a sufferer's 'pathological doubt,' which is recognized as a core feature of the disorder. When this pathological doubt is paired with an intolerance for uncertainty experienced by those with OCD, which is experienced as an intense need to know, the OCD symptoms emerge. Given the unanswerable nature of philosophical and existential questions and debates, it is understandable that some sufferers will gravitate towards these matters and that these matters would become a focus of their OCD.

Treatment

Just as in other cases of OCD, a combination of cognitive and behavior therapy is recommended as the treatment of choice. Often pharmacological treatment is utilized as well. Treatment for these types of cases does not focus on proving the answers to these questions. Settling patients in regard to the possible negative outcome (i.e., death, being alone, not knowing where you are) can be helpful, but it is still not the main target of effective treatment. Treatment focuses on the uncertainty inherent in all of these cases; and, specifically, the intolerance of this uncertainty is what is challenged both cognitively and behaviorally.

Using cognitive therapy techniques, beliefs of patients are challenged, with a goal of educating patients in replacing their irrational beliefs with more rational and healthy views and beliefs. For example, in the case of Jackie, who obsessed over whether she was alive or dead, the belief that the answer mattered and the belief that she could not tolerate this uncertainty would be challenged. Questions such as "What if you were in fact dead, then what?" would be discussed, in order for the patient to understand the relative lack of value in persevering in her thoughts regarding the ambiguity of the issue. Acceptance of the fact that her question could never be definitively answered is an important objective as well.

In regards to behavior therapy, ERP (Exposure and Response Prevention) has been found to be the most effective treatment for OCD. Exposure consists of having a patient confront situations, in a gradual fashion of increasing anxiety, that are either feared or avoided due to their OCD. Response Prevention, the second half of this treatment, is having the patient resist the urge of engaging in a compulsion following an exposure. Exposures are very individualized to the specific situations that are feared and/or avoided. In the case of Rick, who feared going places because he wasn't sure who he would become, many of his exposures would consist of having him go in and out of rooms, and eventually in and out of his house, and then even further, in order to have him face these situations. In the case of Jackie, if she had been avoiding things related to death, exposures might consist of looking at pictures of dead animals and then dead people, reading the obituary of others, and then writing her own obituary or writing her name over an existing obituary, visiting a cemetery, and so on. The basis of this therapy is that over time, when repeatedly exposed to these situations, without engaging in compulsions, the anxiety related to these situations will go down on its own. Of course, all of this should be done gradually and in a manner acceptable to the patient. We at the Bio-Behavioral Institute believe that there are many patients who have philosophical obsessions that are not identified. When questioned, patients begin to recognize them and we have found great success in their treatment with the above mentioned strategies.

If you are interested in joining a group of others who share these types of obsessions, please inquire at the Bio-Behavioral Institute to see if you qualify. Our experience indicates that many patients with these types of obsessions feel alone and isolated from other OCD patients. If this is your type of OCD, you do not need to feel this way. These obsessions respond very well to the right treatment.

Advanced Behavior Therapy Institute Using Motivational Interviewing to Enhance Treatment Adherence in OCD Sufferers

Obsessive Compulsive Foundation
14th Annual Conference
Advanced Behavior Therapy Institute
Thursday July 19, 2007
12:30 pm - 6:00 pm
The Woodlands Waterway Marriott Hotel & Convention Center
The Woodlands, TX

Using Motivational Interviewing to Enhance Treatment Adherence in OCD Sufferers

Allan Zuckoff, Ph.D., Assistant Professor of Psychiatry, Western Psychiatric Institute and Clinic, University of Pittsburgh School of Medicine, in Pittsburgh, Pennsylvania

Cognitive behavioral therapy is highly efficacious in the treatment of OCD. However, OCD patients commonly miss sessions, balk at therapist-directed in-session activities, choose not to complete homework assignments, and drop out prematurely – all of which can limit treatment effectiveness and place patients at risk for relapse. Motivational interviewing (MI) is a client-centered, goal-oriented method for enhancing intrinsic motivation for change and treatment by exploring and resolving ambivalence. MI has been shown to enhance treatment adherence and improve outcomes in substance abuse and health behavior settings, and shows similar promise in the treatment of anxiety disorders.

In collaboration with faculty at Columbia University's Obsessive-Compulsive Disorder Research Clinic, Dr. Zuckoff has been working to adapt MI for use with patients with OCD. Through lecture, demonstrations, role-play, case presentation, and discussion, this workshop will provide an introduction to MI and its integration into CBT for OCD.

Participants will learn:

1. The conceptual and empirical basis for motivational intervention

2. Key principles and practices of motivational interviewing

3. How to work with ambivalence for change to prepare patients for treatment

4. How to avoid provoking resistance to OCD treatment and to reduce it when it arises

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"AM I OK TODAY?": BDD AND THE ROLE OF SELF-ESTEEM

By Scott M. Granet, LCSW

When I first started speaking on Body Dysmorphic Disorder (BDD) at the OCF Annual Conferences about 10 years ago, it seemed that very few people knew much about the disorder. Of course, there was Katharine Phillips' book, *The Broken Mirror*, which is now in its 2nd edition. It is very well known to those of us either treating the disorder or those who are living with it. Outside of that, however, there was very little information on the subject, except for mention in some books, journal articles, and a few other sources. Fortunately, awareness of the disorder has changed considerably over recent years as more books and articles have been written about BDD. In addition, several TV shows and popular magazines have done feature stories on it. The first BDD conference in North America was held at UCLA in 2005, and that was followed by the 2006 conference held in New York at Hofstra University. There is also the newly formed BDD Foundation in the UK, BDDCentral.com, and a few other web based support groups. There are more therapists and clinics treating BDD today around the world than ever before. Yes, a lot has changed in just the past several years.

Not so long ago, when giving speeches I always found it necessary to describe BDD in some detail, as few people really knew what it was. That was even true in my classes with other mental health professionals, as oftentimes they too were unaware of the existence of BDD. While that is still the case to some extent, there is no question that more people know about the disorder now than even just a few years ago. Certainly, many people now know that BDD is essentially about obsessions pertaining to perceived flaws in physical appearance, and that cognitive-behavioral therapy, along with medications, is the treatment of choice, just as it is for OCD.

There are many similarities between OCD and BDD, one of which is the strong element of shame that people with OCD and BDD live with. It is widely recognized that BDD sufferers, however, take that many steps further as indicated by using words such as "disgust" to describe how they feel about their appearance and, often, about themselves. While some of these people are participating in CBT, they still may languish in therapy without seeing satisfactory results. This is where I believe the role of self-esteem may need to be addressed more aggressively. Certainly, a skilled cognitive-behavioral therapist will be exploring that through examining a client's negative thoughts and core beliefs. As it applies to BDD, the latter will generally come in the form of beliefs such as "I'm worthless without my hair," or "I'm unlovable with skin like this."

Is this really the way most people feel about themselves? Of course not. Only people with BDD think this way. Everybody has appearance flaws, but how many contemplate suicide over them? Well, people with BDD often do and at a rate which is higher than for many other psychiatric disorders. In my practice, I have found those who get well are those who come to believe that their obsessive thoughts stem from having BDD and not from just a desire or need to look better. How many people define themselves based on their appearance? How many would say that their hair, nose, and skin are more important than any other part of their lives? How many would rather have some terminal disease than having to live with a face "this ugly." I wish I could say that these types of thoughts are rare, but unfortunately I come into contact with them far too often in the clients I treat. If you are someone with BDD and steadfastly hold onto thoughts like that, getting well will be very difficult. It is the willingness to think "outside the box" which will propel someone to get better.

In discussing self-esteem, let's not forget about other important aspects of life such as work, school, relationships, and hobbies. "Nope, too ugly to have any of that," a BDD sufferer might say. If you are such a person, you might think that your appearance has to improve before you can sufficiently engage in these types of pursuits. Think again. If you wait for that, the BDD will win every time. You must put those and other meaningful activities into to your life first, and begin to improve your self-esteem that way. No one is just their hair, their eyes, their chin, etc. Most people define themselves based on other parts of life, and that shouldn't be any less true for people with BDD.

While building one's self-esteem in other areas is important, it does not take the place of cognitive-behavior therapy (CBT), which of course needs to happen. It just gives the BDD less of an opportunity to flourish. Consider this test if you are someone fighting BDD: first, make a decision to go look at the particular body part(s) which concerns you. Before you look in the mirror notice what thoughts begin surfacing. My guess is there are thoughts such as "I hope I look OK," or "I hope I don't look so bad," or quite possibly it's worse with such thoughts as "I know I'm going to look disgusting!" I would ask you to consider something else as you're having those thoughts. Is this just about how you look? In some way, aren't you really saying "I hope I'm OK today," "I hope people will accept me," or perhaps "I hope I can even like myself." There is a tremendous difference between "I hope I'm OK," and "I hope I look OK." Yet most people with BDD equate the two. How we look shouldn't define how we feel about ourselves, though I realize I would be ignoring the obvious by overlooking that we live in a society that promotes that type of thinking. But, it is also safe to say that people with BDD take that to an extreme.

It is also safe to say that many with BDD are much kinder to others than they are to themselves when it comes to appearance. If you are someone with BDD, you probably have friends who are balding, have acne, or have something else like wrinkles or a nose that may appear to be crooked in some way. Do you like these people any less because of that? Probably not. You might actually consider doing so to be unreasonable. If that's the case, then why not treat yourself with the same kindness? And what about their self-esteem? Do these appearance issues seem to interfere with their daily functioning like it might for someone with BDD? If you are close to these people, asking them may help give you some insight into this issue. While some of these same people may wish the body part looked different, does it seem to change how they feel about themselves? Does it fundamentally change who they are? Again, probably not.

So what's the point of all this? The point is self-esteem. People are more than the fullness of their hair, the shape of their nose, or the tone of their skin. If you have BDD and look to "fix" those and other parts in an attempt to feel better, you are likely to be very disappointed and very frustrated, as is well documented in the literature. Self-esteem comes from many sources, and how we look may be one of them. But aren't there other factors? Isn't how we treat others important? What about how we are at being a spouse, a parent, a friend, an employee, a student or whether we are kind, understanding, and compassionate? Most people would probably agree that those roles and qualities are in fact more important than how we look. So while you're working on your appearance concerns in therapy, don't forget about these other issues. Work on those too, and you just may begin to see more progress with the BDD. You may also have a very different answer to the question, "Am I OK today?"

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Mindfulness Meditation As A Way To Weather The E

By Chris Molnar, Ph.D.,
Director of Mindful Exposure Therapy for Anxiety (META) Center, Abington, PA.
www.meta4stress.com; chris@molnarpsychology.com

It is hard to see what is real when flooded by the dizzying sensations of fear: A pounding heart that seems to have migrated into the neck area. Breathing that feels as if it is through a very narrow or perhaps clogged straw. Gastrointestinal distress and nausea that makes one wonder if they can make it to the bathroom in time. A dessert-dry mouth. A flood of sweat oozing out of pores in order to cool the increasingly hot body. The body that cannot seem to decide if it should freeze in place, take flight, or strike out. These reactions are the body's way of preparing to protect itself from a perceived threat. When fear is extreme, as it can often be during exposure and response prevention (ERP) therapy for OCD, it can interfere with a good therapy outcome (Foa & Kozak, 1986). This is because extreme fear restricts one's perception of both the inner and outer world of reality that contains the "corrective information" that psychologists Michael Kozak and Edna Foa indicate is crucial to adaptive "emotional processing" during ERP. Emotional processing refers to how we sense and perceive internal and external stimuli and events and subsequently experience and express fear as a result of such perception. Although research indicates that extreme fear can interfere with ERP, it also indicates that one must fully experience much more than a mild level of fear during exposure if one is to benefit from ERP. As exposures are repeated, this fear must show habituation (i.e., lessening of fear over time) both within and between exposures if a good outcome is to occur. Just what the optimal level of fear required for successful ERP is, is an art and not yet a matter of scientific knowledge. So how is one to get through the extreme fear and other emotions that arise during the course of ERP in order to realize a life with freedom to move rather than a life imprisoned by OCD? How is one to see the broader reality of now rather than only the fear that is here right now? One must learn to allow and to sit with what Paul Ekman and other emotion theorists call primary emotions. There are only a handful of primary emotions and they include fear, sadness, disgust, anger, surprise, and even joy. These emotions are challenging for almost everyone to sit with, and especially difficult for those with anxiety disorders. Indeed, fighting the experience of primary emotions contributes to the development and maintenance of anxiety and other disorders (Safran & Greenberg, 1991). But allow such emotions we must, because when we become disconnected from our primary emotions we become cut off from essential information about survival and can even have higher rates of health problems (c.f., Molnar, 2003). In what follows, the concepts of both corrective information and emotional processing described by psychologists Michael Kozak and Edna Foa are illustrated, the importance of learning to sit with primary emotions is explained, and finally some cognitive-behavioral and mindfulness meditation practices and concepts that increase one's ability to weather what sometimes feel like storms of emotions are highlighted. As you read keep in mind your experience with storms: they always pass.

First, an example is used to explain what researchers of ERP mean when they say that exposure to corrective information is essential for emotional processing and a good outcome in ERP. To someone with OCD the sensation of an unknown wet liquid (an external stimulus) on a door handle may be perceived (i.e., emotionally processed) as meaning, "I just touched something that can infect and potentially cause me or others harm." When this sort of emotional processing occurs, as it does quite automatically in OCD, information about reality has been incorrectly integrated into an account of what is real and attention narrows onto all that is potentially threatening. When fear rises and attention narrows, it is hard to take in the disconfirming corrective information (i.e., what is real) that will decrease fear, the body thus responds with fear. This further narrows attention to all that is dangerous, and the urge to avoid the danger through a compulsion or some other form of avoidance is strong. One then engages in a compulsion such as repeated hand washing, and attributes not being infected to the compulsion. One thus never gets to see that even if the hands were not washed that harm would not have come (i.e., corrective information) or that the infection could have been coped with surprisingly well (more corrective information). You may be saying that it is always best to wash the hands to avoid infection, but when you have OCD any amount of hand washing is rarely sufficient and awareness tends to be flooded with an inaccurate perception that danger remains even after hand washing. When you have OCD no amount of hand washing will ever suffice. The only way to really move past the OCD is to watch the fear that follows not washing the hands peak and pass repeatedly through repeated and prolonged exposures to situations that bring on the fear. The learning that fear peaks and passes, by the way, is probably the most important corrective information offered through ERP. In order to develop the courage to stay present while fear not only peaks but at times surges to extreme levels, one must change their relationship with fear, approaching, allowing, embracing and befriending it. But first a little bit about what happens when we avoid the experience of fear and other primary emotions. And then some ideas for weathering the emotion storms that inevitably come during ERP and throughout life.

Allowing emotions into awareness is essential to our survival. We must learn to allow and sit with primary emotions in particular if we are to benefit from the corrective information of reality that will insure success with ERP. Primary emotions are to be distinguished from secondary emotions such as the anxiety and depression that can last a lifetime and are associated with avoidance of primary emotional experience. A person who has a good ERP outcome will learn to sit with primary emotions such as fear and observe that primary emotions neither last forever nor destroy a person. Rather fear contains the important information that there is a danger in the here and now. Scientists refer to this as a functional view of emotion. Emotions function to keep us alive so we best pay attention to the information that emotions bring to us. For example, fear signals threat to self or beloved other, sadness signals loss, primary anger signals goal frustration or injustice, disgust signals the need to reject something, surprise signals the need for more information, and joy signals that important needs have been met.

In behavioral terms the negative primary emotions signal loss of rewards / reinforcers (things that sustain life) or the presentation of punishment whereas joy signals attainment of what is rewarding and life-affirming or cessation of punishment. Unlike fear, anxiety is all the wast-

xtreme Fear That Can Impede Exposure Therapy

ed cognitive energy that goes into essentially avoiding death and other losses. Anxiety paradoxically results in one's missing out on life. People with OCD are so busy avoiding death and other loss that they are missing life. Life happens right now and right here in this moment. There is no life in yesterday and no guarantee for tomorrow. Life is this moment so it is a good idea to pay attention to the reality of the moment both internally (primary emotions) and externally. All of it is a source of corrective information.

So how does one prepare to weather the storms of primary emotions that often occur in the beginning stages of ERP and that are inevitable in life? A cognitive-behavioral therapy (CBT) approach takes the perspective that emotions can be quite overwhelming unless broken down into their components. The CBT perspective is that an emotion is a concept and not a tangible thing. If one says, "I have to get control of my fear," then one has a daunting task indeed. After all, fear will occur throughout life because the brain is designed to produce the set of responses we call fear when particular regions in it become active in environments marked by uncertainty. Fear is not a tangible thing that can be controlled. Rather fear, like every emotion, is a theoretical concept. We infer the presence of fear when the body responds with a pounding heart, sweat, and other ways that promote behaviors to protect the self in environments where we perceive a threat and thus believe we are in danger. Belief can be both conscious and unconscious, but we usually always have access to the body and behavior responses that lead us to infer the presence of fear. If we break fear down into the three "B"s of body, behavior, and belief, then we can manage each component of fear. For example, we can slow our breathing to reduce the body response, decide not to avoid what we fear but rather approach it and thus tranform our behavior response, and we can decide only to base our beliefs on what is real. The "tripartite" theory of fear also represents a functional view of emotions and has been written about by one of the same psychologists, Dr. Michael Kozak, responsible for the emotional processing theory of ERP. This theory of fear is at the core of cognitive-behavioral therapy (CBT) for anxiety and other emotional disorders. Any CBT will give a person ways to reduce the 3 "B"s of an emotion. It turns out that the practice of mindfulness meditation, much older than CBT, also offers ways to transform the three "B"s of emotions.

When one behaves with mindfulness one focuses on each moment without the reactivity, judgment, striving, and the attachment that causes unnecessary suffering. Mindfulness meditation and ERP have quite a bit in common. Both are repeated, prolonged, require focused attention, dedicated time, patience. Both are not always fun initially but after some practice can bring joy and lead to peace of mind and clarity of perceptive. Both mindfulness practice and ERP teach a person to let go of conditioned ways of responding that maintain unnecessary suffering. The instructions for mindfulness meditation are even quite similar to the instructions for exposure and response prevention (ERP) therapy. Here is an example of a mindfulness meditation. Notice how the attention is directed to the reality of the moment and sensations occurring in the present just as in ERP. Notice how certain responses are "prevented" in a firm but gentle way as would also occur in skillful ERP.

Try this meditation: "Sitting still yet relaxed and observing the breath, discovering where you most notice the breath in your body right now. Approaching experience with a curiosity and receptivity. Receiving the breath sensations in awareness wherever your attention alights. See if you can discover where you most notice your breath in your body right now without searching, but rather with a stance of allowing and receiving (pause)... How about now (pause)? Maybe noticing the sensations of the air entering and leaving your nose. Perhaps noticing how the temperature changes as the breath flows into and out of the nose – cooler on the inhalation and a bit warmer on the exhalation. Maybe noticing the sensations of the belly rising and falling. Or perhaps perceiving a slight stretching of the skin on the back as the air enters and leaves your lungs... expanding and contracting. Just watching the breath without changing it. If you notice thoughts of judgment about how well you are focusing on the breath, practice redirecting attention to the sensations of the breath, not judging the judging, rather just watching the breath. Whenever you notice that your attention has shifted away from your breath, gently returning to discovering and observing your breath right now in this moment. Without judgment that your mind has wandered, just noticing whatever the mind has wandered to, allowing it fully, and then bringing focus back to the breath...And it is inevitable that the mind will wander...the noticing that the mind has wandered is itself mindfulness. Just direct attention back to the breath. After a while you may notice some unpleasant sensation in the body...perhaps an itch...see if you can breath awareness into the itch without scratching. Observing the itch sensations with curiosity and seeing if the sensations change..." (Molnar, 2007, Mindfulness of breath sensation meditation).

Technically the meditation above is a "concentration meditation" because an object (e.g., the breath) is constantly returned to when the mind wanders to something like and itch or even eventually to the beliefs, body responses, and urges to engage in behavioral avoidance that comprise fear. Concentration meditation prepares one to practice something called "choiceless awareness" that essentially involves allowing into awareness whatever emerges without clinging to it or pushing it away. Both concentration and choiceless awareness are quite useful during exposure therapy and both are part of the mindfulness training that has been shown to reduce unnecessary suffering (Baer, 2003; Kabat-Zinn, 1990). Mindfulness meditation practice trains one to focus attention and fosters the ability to weaken habitual and conditioned patterns of responding. Such responding includes the compulsions practiced to eliminate fear in the short run that actually maintain fear in the long run. Repeated practice of meditation, just like repeated ERP practice, is associated with development of a crucial insight on a body (verses just an intellectual) level: all of suffering is impermanent (even without compulsions). This insight prepares one to weather the fear, disgust, sadness, anger, surprise, and even joy during exposure therapy because it arms one with the knowledge that no emotion and in fact no thing lasts forever. The insight that everything is impermanent can be both liberating and can itself evoke fear. Don't worry: Even the fear associated with the insight that everything is impermanent will pass and your attention will be onto the fact that you are hungry, thirsty, cold, or have another itch.

In order for mindfulness meditation to optimally prepare one for ERP serious practice is needed such as the 45 minutes

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Mindfulness Meditation

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per day prescribed by the Mindfulness Based Stress Reduction (MBSR) curriculum. Any dedicated time each day, even 5 minutes, will contribute to preparing one to weather intense emotions. Just like with ERP: the more one practices the more one benefits. Five minutes daily is much better than no minutes a day for practice and will likely lead to a habit of greater practice. This is because even with just five minutes of sitting and focusing mindfully on the breath or some other object, one gets a taste of the peace and stillness of mind that accompanies regular mindfulness meditation. Just be sure not to practice right before bed when first learning to meditate. As Jon Kabat Zinn says, "The point is to fall awake!" If you discover a certain peace of mind, as many do, then you may want to increase the time of practice. If you keep up the practice you will be much better prepared to handle the intense fear that can occur during ERP.

One way to increase motivation to practice is to develop the perspective fostered by a therapy called motivational enhancement therapy that was developed by Dr. Bill Miller to help addicts make behavioral changes. Essentially this approach involves identifying what is most valued in life and then determining whether or not one's behaviors are consistent with these values. This approach also involves looking at the short and long term costs and benefits of changing versus staying the same. When behavior changes are seen as a way to live that is most consistent with what is valued and as introducing other benefits that outweigh the benefits of staying the same then a person is likely to make changes in behavior. Of course, the costs of making changes must also be less than the costs of staying the same. For example, when one can view daily mindfulness meditation practice as a way to be present in relationships with others, such presence is highly valued. When a person perceives that the long term benefits that meditation introduces are much more desirable than the short term decrease in anxiety that comes from OCD, then it is possible that a person will be more likely to practice meditation. This is especially so if the cost of practice (time) is minimal compared to the cost of staying the same (chronic anxiety and all that comes with it).

Another mindfulness practice that helps one to stay with the reality of now without the reactivity so typical of OCD and the other anxiety disorders is to practice what is called "metta". Metta is a word from the earliest Buddhist texts that translates into loving kindness (www.metta.org). Although it is a Buddhist word, and although mindfulness training and metta practice are derived from early Buddhist teachings, the wisdom of both are universally applicable. One does not have to be a Buddhist to practice mindfulness or metta and to benefit from it. To practice metta one sets about to allow reality unconditionally as it is now rather than fighting it. Practicing metta is a radical act of love in that it decreases suffering in self and others. Metta and the intention to allow reality as it is promote an ability to see and accept reality with clarity and patience rather with the judgment, reactivity, and clinging that all contribute to suffering. And if the reality of now is full of fear then that means not fighting it, but rather letting it be. Metta does not mean throwing up the hands and saying "I am helpless." Rather, metta takes great strength and courage to look the moment in the face and say, "yes I see you as you are." And it is always best to see the moment as it is for this is the same as being exposed to corrective information and being connected to the needs signaled by emotions that are grounded in what is real.

If it seems that metta and mindfulness are similar, this is because metta is at the core of mindfulness. With enough attention to the reality of the moment without judgment or reactivity one will naturally begin to become a loving and kind presence that has the courage and compassion to see clearly. One perspective that can develop is that those who cause suffering are suffering themselves. Thus, it is also helpful for those who love people with OCD to practice mindfulness and metta. Although it can be quite frustrating to have OCD, one benefit of having it is that it opens up the door to a new way of life in which extreme levels of suffering can be transformed into extreme levels of loving presence and courage. Many clients who practice mindfulness meditation naturally become excellent cognitive therapists because a core skill of cognitive therapy is to relate and thus talk with the self as you would talk to a child you loved dearly. If you can learn to respond mindfully to your OCD symptoms, breathing into and allowing the fear that comes with exposures just as you breath into an itch that occurs during meditation until you observe its impermanence, then you can learn at a visceral level that fear cannot last forever and it will not destroy you. And if you are still observing mindfully after the fear comes and goes you will learn that the feared outcome did not occur or that the outcome was much better than you imagined or you coped well with it. And with lots of practice you can learn to be a loving presence for yourself and others and you will substantially decrease your tendency to suffer unnecessarily. Perhaps metta can also stand for Mindful Exposure Therapy to Transform the Anxiety of OCD into loving presence.

There are many ways to learn mindfulness meditation. A simple way to begin is to just sit still and focus on sensations of the breath that you can discover in your body. You can also focus on some other sensation, such as sound, rather than the breath. Just focus on one thing at a time. Do not search for or seek to create sensations, but rather let them emerge into awareness. Be careful not to strive to become relaxed or to achieve any special state at all. Just watch the mind from the perspective of the one who observes impartially but not dispassionately. This observing part of you is awareness and has always been with you, seen everything as it has unfolded. When you notice attention wandering from the breath, do not be critical of yourself. Rather notice where the mind has gone and then gently but firmly bring attention back to the breath. If an urge to move or itch arises, see if you can postpone reacting and rather observe with curiosity this urge. See if it changes or transforms. Anchor yourself always in the breath, returning to it again and again, without judgment that what emerges is good or bad but rather with patience and receptivity. Know that noticing that the mind has wandered is itself mindfulness. Do not judge this as good or bad; just notice it and then return again and again to the breath or some other object of focus. Practice metta and thus receptivity and kindness toward your experience. If an obsession emerges, just observe the obsession and all of the accompanying sensations that may try to hijack awareness. With practice you will take the wheel of your life.

An excellent resource for learning meditation is Jon Kabat-Zinn's book, "Full Catastrophe Living", 1990, New York, Delacorte.

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

To be eligible, you must also:

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

We offer:

$25 per visit for time and travel

Physical examination, EKG, laboratory work-up, and study medication at no cost to you.

If you are interested in participating in this research study, please call The Psychiatry Research Center at 402-660-2903 or Angie at 402-345-8828 x 24
Creighton University
Department of Psychiatry
3528 Dodge Street
Omaha, NE 68131

Acamprosate (Campral) for SSRI resistant Obsessive Compulsive Disorder

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

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

Intensive CBT Training Workshops for Professionals

Cape Cod Institute, 2007
Presented by Aureen Pinto Wagner, Ph.D.
July 30 through August 3, 2007: **Cognitive-Behavioral Therapy for OCD and Anxiety: Effective and User-Friendly Treatment for Children and Adolescents.** This workshop is designed for clinicians and school personnel with beginner to intermediate experience in CBT. The focus is on the application of empirically-sound, developmentally sensitive and appealing CBT approaches that are feasible in clinical settings and designed to optimize motivation and treatment compliance in youngsters. Opportunities for learning will be maximized through clinical vignettes, video-taped demonstrations, case discussions, Teaching Tools and detailed handouts. Strategies for building treatment-readiness, collaborating with parents, managing anxiety in school, working with reluctant children, relapse prevention, and challenges in treatment will be discussed.

August 6 through 10, 2007: **Cognitive-Behavioral Therapy for OCD and Anxiety: Complexities and Challenges in Treating Children and Adolescents.** In this unique workshop, Dr. Wagner will cover anxiety-related topics that are not typically covered in depth in any single workshop. It is designed for clinicians and school professionals with at least intermediate experience with CBT, or those who have attended Dr. Wagner's previous workshops. The focus is on conceptualizing, strategizing and intervening with hard-to-treat and unusual symptoms, co-morbidities, overlapping symptom dimensions, and crisis-prone situations. Step-by-step clinical decision-making, selection and application of strategies through different phases of treatment will be reviewed. This workshop will integrate the science and the art of CBT, including the subtleties and the nuances of delivery and the complexities of the therapeutic alliance. Case discussions, video clips, "clinical pearls" and structured exercises will be woven through the workshop. For more information or to register, please visit www.Cape.org or call 888-394-9293.

Are You a Packrat, Hoarder, Clutterer?

Research Study Offering Free Medication Treatment.

The University of California at San Diego OCD Program is looking for people who have problems with hoarding, saving, or clutter to take part in a study that is providing:

- 12 weeks free medication treatment
- Brain imaging scans
- Diagnostic Evaluation
- Neuropsychological Evaluation

For more information call (858) 642-3472

Does Your Child Need to do Things Over and Over Again? Does He or She Have Recurrent and Bothersome Thoughts or Images?

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

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

You must be between the ages of 8 and 17 years old to be eligible for this study. If you are eligible to participate in this study, you will be randomly assigned, that is by chance as in the "flip of a coin," to receive either the study medication (D-Cycloserine) or a sugar pill in addition to being seen in therapy. The therapy will be held weekly (90 minutes each session) for 8 weeks. There will also be 3 psychiatric evaluations that take place. Two of these evaluations will be comprehensive and take about 3 hours each (immediately before and after treatment). During each of these, your child will have a small amount of blood withdrawn for lab tests. One evaluation will be short and take place in the middle of treatment. Study medication, treatment, laboratory tests, and the evaluations will be provided at no charge. Participants will also receive financial compensation for their time. If interested, please call Dr. Eric Storch of the University of Florida at (352) 392-3613.

OCD and Hoarding Study

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

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

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

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to $180.
If you are interested in participating and have any questions, please contact Jessica Rasmussen, B.A., at Boston University at (617) 358-4213 or (617) 353-9610, or Kristin Fitch, B.A., at The Institute of Living in Hartford, CT at (860) 545-7574.

Do you suffer from obsessive compulsive disorder?

Participants Wanted

Research Study on the Effectiveness of Duloxetine (Cymbalta) in Treating Obsessive Compulsive Disorder. Dr. Darin Dougherty of Massachusetts General Hospital OCD Clinic and Research Unit is conducting a research study on the use of duloxetine (Cymbalta) to reduce the symptoms associated with obsessive compulsive disorder (OCD). If you have OCD, you may be eligible to participate in this study.

To be eligible you must:

- be between 18-65 years old.
- live within 1 hour of Boston .
- be able to participate for 17 weeks.
- not be pregnant or breastfeeding.

If you are interested in this study and believe you are eligible, please contact Mariko Jameson at (617) 726-9281.

Drug Study for Hair Pullers

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

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

Advanced Behavior Therapy Institute

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5. How to strengthen OCD patients' ongoing commitment to treatment and change

6. Continuing Education Credits Available

This workshop is limited to professionals only. For a registration brochure, contact Jeannette Cole, deputy director of the OCF, at 203.401.2069 or cole@ocfoundation.org or visit the web at www.ocfoundation.org under Behavior Therapy Institutes. Cost is $100 before July 1, 2007; $125 after July 1,2007

Book Review

Buried In Treasures: Help for Compulsive Acquiring, Saving and Hoarding

By David F. Tolin, Ph.D., Institute of Living, Hartford, CT
Randy O. Frost, Ph.D., Smith College, Northhampton, MA
Gail Steketee, Ph.D., Boston University School of Social Work, Boston, MA

Review by Jerry Bubrick, Ph.D., Private Practice, Montclair, NJ

Ok, here's a riddle: What is better than one new, well-written book on understanding and treating compulsive hoarding? The answer: two new, well-written books on understanding and treating compulsive hoarding!

That's right, in the last issue of the OCF Newsletter, I was honored to review "Compulsive Hoarding and Acquiring" in the "Treatments that Work" series by Gail Steketee, Ph.D. and Randy O. Frost, Ph.D. In this issue, I'm honored to review "Buried in Treasures: Help for Compulsive Acquiring, Saving and Hoarding" by Drs. David Tolin, Randy Frost, and Gail Steketee. I consider this a "must-read" for anyone with an interest in compulsive hoarding.

"Buried in Treasures" is a grounded, easy to read book written in self-help format and truly is a great addition to the existing literature on compulsive hoarding. It was designed to help a wide variety of people interested in learning about and treating compulsive hoarding. There are scores of useful tips and strategies for those who suffer from hoarding, friends and family members who want to help a loved one, and for treatment professionals who want to learn effective strategies to help treat their own clients with hoarding.

The book starts out by giving the reader a comprehensive description of the essential diagnostic criteria for compulsive hoarding. Other variables including attention, memory, decision making, perfectionism and avoidance are discussed and allow the reader to understand the various factors that contribute to the complexity of hoarding. The reader is then able to complete self assessment ratings for his/her hoarding severity, activities of daily living, living conditions and safety. The reader can score his/her scales and then choose to focus on some or all of the treatment to address the areas of concern.

It has been my experience in treating compulsive hoarding that often clients' expectations in entering treatment is that house clutter is the main concern, and once the clutter is removed, everyone lives happily ever after. I believe the authors address this expectation quite well and help the reader understand the cognitive behavioral perspective of thinking, feeling, doing, and how that results in clutter and chaos. They present the problem as not just a house problem, but also as a "person problem" which allows for better insight into how clutter is built and maintained. They eloquently point out how non-hoarders value themselves on what they have accomplished, whereas hoarders may value themselves by what they own.

I found chapters 4 and 5 especially meaningful and thoughtful. These chapters discuss the various "bad guys" and "good guys" that a hoarder or family may encounter when attempting to overcome the hoarding problem. Topics under the "bad guys" include: readiness for change, fear of making mistakes, beliefs about attachments, overthinking, avoidance, etc. The reader is able to assess which "bad guys" are the most significant to him/her throughout the process. The reader then gets introduced to the "good guys." Topics include: keeping goals in mind, downward arrow techniques, behavioral experiments, and developing the right skills. The authors later go into depth regarding these techniques to aid the reader in maximizing his/her cleaning efforts.

The following several chapters help the reader understand and improve motivational concerns and teach the reader how to effectively categorize and sort through clutter. The authors do a great job of addressing commonly asked questions regarding what to keep and for how long. They differentiate between what to keep for 1 year, 6 years and even forever. Unfortunately (for most readers), the "keep indefinitely" category only contains four items.

The issue of how to effectively reduce the acquisition of new possessions is also addressed effectively. The authors do a wonderful job of giving specific guidelines and rules for acquiring new possessions. There is a handy cut-out reminder tool on page 137 that reminds the reader of all the information presented in the chapter. Listed are the essential guidelines and reminders including: do you really "need" this, do you have money to pay for it, do you have room for it, will you regret acquiring this in a week, etc.

In fact, these suggestions certainly apply to non-hoarders as well. Don't tell anyone, but my cut-out is now in my wife's pocketbook and hopefully she will find it prior to buying some new shoes!!!

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