OCD NEWSLETTER

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FROM THE FOUNDATION

Dear Readers,

I wanted to bring you up to date on what's been happening at the Foundation for the last few months. The good news is we are emerging; the bad news is that the Foundation has been caught in a technological nightmare for the last half year. We have been bushwhacked and harassed by an idiosyncratic phone system that rang everywhere at once, erased all the current voice-mail on a whim and replaced it with messages from January 31, and crackles like cellophane.

Our software program that was supposed to keep each and every member's name, address and telephone number along with renewal date safe and ready to be called up turned renegade in October, refusing to let anyone access the information needed to address the newsletter and renewal notices. Not only wouldn't the program release laboriously inputted information, it refused like a tight-mouthed two-year old to accept anymore. No updates.

It must have been a conspiracy because our stuffing, stamping, sealing and mailing machines broke down in sequence like a transmission the day after the warranties run out.

Repair people took up residence here. Stroking chins and grimacing. They came to fix the software, the hardware, the cables, the whatzits, and the hoozies. One mechanism would wheeze to a start while another ground to a halt. The computer representative blaming the postage person who swore it was the integrating mailer that was at fault.

We bought a new server to be able to maintain and utilize the data that is the wellspring of the Foundation's activities. We visited with the leasors of the machines that are supposed to separate, address, stamp, seal and mail information to our members. We visited with people who are saying they can perform all these functions at their place for less money. We are doing the math right now.

We have been trying to communicate with the phone company - the same one that touts itself as a communications problem solver for small businesses in its ad campaign. We have met with four people now. The fifth is scheduled. It seems that designing a phone system that doesn't go directly to voice-mail is not one of the solutions it provides. But I have OCD. I am used to doing things over and over. Soon, you will be able to call here and talk to whomever you want.

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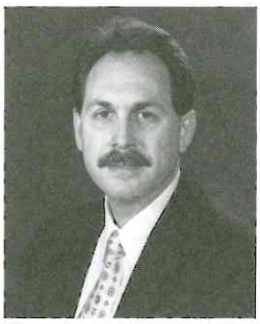
SCOTT J. RAUCH, M.D., KEYNOTE SPEAKER AT SEVENTH ANNUAL CONFERENCE



Dr. Scott Rauch will be the keynote speaker this year at the OC Foundation's Annual Conference in Schaumburg, Illinois. The Conference is scheduled for August 11-13. Dr. Rauch, who is Associate Professor of Psychiatry at Harvard Medical School and Associate Chief of Psychiatry for Neuroscience Research at Massachusetts General Hospital, where he also serves as Director of Psychiatric Neuroimaging Research and Assistant Radiological Scientist in Neuroimaging, will speak on "Recent Research into Brain Mechanisms of OCD." He will discuss the advances that have been made in neuroimaging and how those have started to unlock the secrets of the neurobiology of OCD.

As a clinician at Massachusetts General Hospital, he provides consultation and patient care at the Obsessive Compulsive Disorders Institute and evaluates neurosurgical candidates as a member of the Cingulotomy Assessment Committee.

Dr. Rauch has contributed over 125 publications to the scientific literature and currently serves on the editorial boards of four journals. He is a member of the scientific advisory boards for both Obsessive Compulsive Foundation and the ADAA. Dr. Rauch completed his psychiatry residency and functional imaging fellowship training at Massachusetts General Hospital. ■

IN THIS ISSUE

MIMICKING OCD

Charles K. Bunch, M. Counselor, NCC, Ph.D., Boise, ID

Have you failed or moderately improved with treatment? If so, you may have an OCD mimic.

There is a type of bipolar disorder that is almost a perfect mimic. It is such a good mimic that diagnosing it is like trying to tell a Hong Kong watch from a Rolex. Many sufferers, clinicians, and medical doctors miss this one altogether. The result of this can be years of needless suffering, and in one case I knew, over $100,000.00 in medical expenses for hospitalizations and outpatient treatment.

Patients who have this are often confused because they have been told that they are just a medication non-responder or that they need one more medication added to their current cocktail of medications. They have often been assured that without doubt they have OCD.

I am an anxiety disorder therapist who has been treating individuals for 20 years. After several years of pondering the cases of OCD suffers who were not responding to treatment, I began asking more questions of my clients, and sought to step outside the bounds. The bounds were two:

1. Following diagnosis only by the criteria set forth in OCD books or the Diagnostic Statistical Manual-IV.
2. Assuming that if things are not working, the cognitive-behavioral work must be modified or intensified.

After several years of observation and dozens of workshops from many fields of psychiatry and counseling, I developed questions that aid me in appropriate diagnosis and treatment.

A case study

James is 17. He has been in treatment for OCD for 1 year. Both his doctor and therapist feel assured that he has only OCD, and they are seeking to increase his dosages of three current anti-obsessional antidepressants.

James responds to the dosage increase for a day, and then falls back to a place of no response. When he first tried an antidepressant, he had two weeks of recovery and euphoria, and then that went away. Oddly, the OCD behavior abated almost completely during this period.

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Participants Sought

Michigan Seminar for OCD Kids and Adolescents and Their Families

SHEPPARD'S F.L.O.C.K. is presenting a day-long seminar (9:30-3:00p.m.), for children and adolescents with OCD and/or Trichotillomania on May 20, 2000, at first Baptist Church in Plymouth, Michigan. There will be separate programs for families and for the kids with OCD/Trichotillomania. Therapists, including Gregory Hanna, M.D.; Joseph A. Himle, Ph.D.; Eliza Lorch, MA; Laura Nisenson, Ph.D.; Dan Fisch, MSW; David Rosenberg, M.D.; and Carol Stewart, RNC, will present talks on every aspect of COD including: genetics, MRI brain scans, medication, understanding and assisting a child with their Exposure & Response Prevention Therapy. The kids will be able to meet, talk and play with other kids who have OCD or Trich. Workshops for the kids, running concurrently with the presentations for their families, include understanding Exposure & Response Prevention Therapy, racing thoughts, sleep problems and anger management. For more information and registration forms, call 734-525-7641.

Compulsive Hoarding Study

Our research project funded by the OCF is entitled "Functional Neuroanatomy of Obsessive-Compulsive Hoarding." Hoarding is defined as the acquisition of, and inability to discard worthless items even though they appear to have no value. Hoarding and saving symptoms, found in up to 30% of OCD patients, are part of a discrete clinical syndrome that also includes indecisiveness, perfectionism, procrastination, and avoidance. This syndrome responds poorly to standard treatments for OCD and can become disabling. A better understanding of the neurobiology of compulsive hoarding is needed to develop more effective treatments for compulsive hoarding. Functional brain imaging research using positron emission tomography (PET) has led to a greater understanding of the neurobiology of OCD. Our study is using PET to identify brain metabolic patterns that are associated with the compulsive hoarding syndrome, as well as patterns that predict response to treatment. Each subject will receive two PET scans, one before and one after 12 weeks of treatment with paroxetine (Paxil 40-60mg/day). Those who do not respond well to paroxetine are eligible to receive adjunctive treatments. Thus far, eight subject with the compulsive hoarding syndrome have completed the study. We need at least another ten subjects before we can reliably compare their brain imaging data to that of 32 other subjects with non-hoarding OCD and to 16 normal control subjects, to identify brain metabolic patterns that differentiate them, and that may predict response to particular treatments. Anyone interested in participating in our study should call Sanjaya Saxena, M.D., at UCLA Neuropsychiatric Program, at 310-794-7305 for information and evaluation.

Obsessive Compulsive Disorders Institute To Begin Fast Track Program

The Massachusetts General Hospital OCD Institute, located on the grounds of McLean Hospital in Belmont, Massachusetts, seven miles west of Boston, has successfully specialized in residential behaviorally oriented treatment of obsessive compulsive disorders (OCD) since 1997. During that period, in addition to treating a majority of patients with very complicated, refractory OCD, the Institute has also treated a number of patients who came to the Institute with the goal of working very intensively on a particular OC symptom which they needed to bring under control in a short period of time so that they could resume their job or schooling. These patients responded rapidly and well to the intense treatment that our residential program of Exposure and Response Prevention provided. Their treatment goals would have been very difficult and time consuming to accomplish in an outpatient setting. Many of these patients were able to use the OCD Institute effectively for a short period of time and were able to return to college, medical school or their places of employment. Beginning in January, 2000, the MGH-OCD Institute began an intensive Fast Track treatment program within its residential program for OCD patients. If you or someone you know might benefit from a short term, residential, intensive behavioral program, are highly motivated to work intensively to rapidly achieve very specific treatment goals, contact the Program Manager, Diane Baney, RN, MBA at 617-855-3279. The Fast Track Program is also under the clinical direction of Drs. Michael Jenike, William Minichiello and Lee Baer.

Studies at Stanford and UCincinnati

We plan to enroll 38 patients at Stanford and 38 at the University of Cincinnati. Half will be randomly assigned (by chance) to pulse loaded intravenous Anafranil, half to pulse loaded placebo. Five days after finishing the pulse loading of intravenous Anafranil or intravenous placebo, all patients will start 12 weeks of treatment with oral Anafranil. Patients must be at Stanford or Cincinnati for 3 days for evaluation and the administration of intravenous medication. But the 2-week oral Anafranil portion of the study can be completed in the patient's home city with the help of the patient's usual treating psychiatrist.

Who is eligible:

To be eligible, patients must be 18 to 55 years of age, have moderately severe or severe OCD of at least one year's duration, and have failed to benefit substantially from 2 trials of anti-OCD medications. Patients who have failed to benefit from previous trials of Anafranil are eligible for this study.

We will exclude patients who:
are pregnant, nursing, or of child-bearing potential and not using a contraceptive method judged effective by the investigator, have certain other psychiatric disorders, have serious or unstable medical problems, have a history of seizures, cannot stop all other psychiatric medications, and those who wish to continue in formal behavior therapy.

Benefits:

The benefit to the patient is a careful review of symptoms and treatments tried, and the possibility that intravenous Anafranil may help relieve the patient's symptoms. We cannot and do not guarantee that patients will receive any benefit from participating in this study.

Contact Information:

Stanford Medical Center
Michael Elliott, Clinical Research Manager
650-725-5180
m.elliott@stanford.edu

University of Cincinnati
LaDonna Baines, Clinical Research Coordinator
513-558-5512
Ladonna.baines@psychiatry.uc.edu

Rogers Memorial Hospital Opens Anxiety Disorder Partial Program

Rogers Hospital's Milwaukee location has opened the Midwest's only anxiety disorder partial program. Rogers Memorial Hospital continues its mission to develop cost-effective care with the fall 1999 opening of its partial hospitalization program specifically for treating anxiety disorders. Located at the hospital's Milwaukee location at 5000 South 110th Street in Greenfield, the new program is designed to fill a need in both Southeastern Wisconsin and regionally for individuals where outpatient treatment has not been effective. The program's goal is to reduce anxiety disorder symptoms to a manageable level for male and female children, adolescents and adults, who meet the admission criteria. Those interested in participating in the program will undergo an extensive evaluation to assess the need for treatment prior to beginning the partial hospitalization program. Covered by most insurance carriers, the program has 12 treatment sessions that take place from 3:00p.m. to 6:00p.m., Monday

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through Thursday. A combined cognitive behavioral therapy (CBT) and medication therapy approach is used during the three-week program that provides individuals with the necessary skills to be effective in managing anxiety-related symptoms. Following discharge, individuals are seen over a period of time to complete the program. The Anxiety Disorders Program is led by senior behavioral therapist Jennifer Christeson, Ph.D. candidate, and supervised by Bradley Riemann, Ph.D., clinical director of the Obsessive-Compulsive Disorder Center at Rogers Memorial Hospital. Medical supervision of the program is provided by board-certified child and adolescent psychiatrist Kambiz Pahlavan, M.D. Earl Kessler is program director. For more information about the Anxiety Disorders Program at Rogers Memorial, please call 1-800-767-4411.

Intravenous Clomipramine Treatment Study available at the NYS Psychiatric Institute/Columbia University Department of Psychiatry. IV Clomipramine may be particularly helpful for patients who have not benefited sufficiently from other medication treatments. This double-blind study provides free hospitalization, free treatment, and partial travel reimbursement. Prior research indicated a responder rate of 43% one week after the 14 infusions for patients who responded poorly to oral clomipramine. For more information, call Dr. Feinstein at 212-543-5132.

Rogers Memorial Hospital Offers Partial Hospitalization Treatment Plans

Rogers Memorial Hospital's OCD Center has partial program for moderate to severe cases of OCD. In addition to the Obsessive-Compulsive Disorder Center at Rogers Memorial Hospital's residential program, the Center provides an intensive three-week hospitalization or partial treatment program focusing on Exposure and Response Prevention Therapy. To maximize effectiveness of the treatment, it must be done intensively. Usually quick improvements are seen, sometimes as early as the end of the first week. Treatment has long lasting effects, no side effects, and has success rates as high as 85 percent. Roger Memorial's partial program uses a combination approach, taking advantage of the effectiveness of Exposure and Response Prevention and medication to produce the best results. For more information about Exposure and Response Prevention Therapy and the Obsessive-Compulsive Disorder Center at Rogers Memorial Hospital, please call 1-800-767-4411.

Body Dysmorphic Disorder

Do you have Body Dysmorphic Disorder? Are you excessively preoccupied with an aspect of your appearance which you consider defective? Do you frequently check or avoid mirrors, compare yourself with others, spend excessive time in grooming activities, or ask other for reassurance about your appearance? Does this concern about your physical appearance lead to low self-esteem, social isolation, problems with work or school, anxiety, or depression? A UCLA research program is looking for people with Body Dysmorphic Disorder to take part in a study which is providing 3 months of free Cognitive Behavior Therapy. For more information call (310) 794-1474. Applicants will be screened for participation.

Cognitive Therapy for OCD

This study is being conducted by members of the psychology department at the University of North Carolina at Chapel Hill. The aim is to examine the effectiveness of cognitive therapy for OCD. Although this approach is still experimental, other research studies have shown that it may be a promising alternative to the treatments that are currently available. Following participation in the study, all participants will be given the option to continue treatment in our clinic with a treatment of known efficacy. The treatment offered through the study consists of twelve-18 weekly sessions. The treatment also requires consistent completion of between-session homework exercises. Treatment is provided free of charge and does not require use of medication.

ELIGIBILITY:

People with OCD as their primary complaint. Participants must travel to Chapel Hill, North Carolina, each week.

BENEFITS:

Based on previous studies on the effectiveness of this and related treatments, the investigators expect that you will experience a reduction in obsessive-compulsive symptom severity. If you do not improve, you will be directed to other treatments that may help. In such a case, the thorough assessment you will have had should be helpful in the new treatment, if you give your permission for it to be shared. Furthermore, the information gathered in this study will be used to develop improved treatments for OCD, and ultimately may help other people who suffer from the disorder.

CONTACT INFO:

For more information about the free treatment, call the Anxiety Treatment Center at the Department of Clinical Psychology, UNC: 919-962-2507. ■

What We Do When We Aren't Checking

This year at the Seventh Annual Conference in Schaumburg, Illinois, there is going to be an annex to the Bookstore, where products made by people with OCD will be sold. The theme of this "Sales Annex" is "What we do when we aren't checking." It will feature all types of goods made by people with OCD.

The first stock item is a CD written and produced by a former rock-n-roller turned computer genius.

The store will be managed by Rob Lancer from Long Island, New York. Rob, who has OCD, has recently been accepted at Hofstra University for graduate school.

"The idea behind the "Sales Annex", according to Patricia Perkins-Doyle, the OC Foundation's executive director, is to show what people with OCD do and support their work. Sort of creating our own economic circle, on a small scale."

The "Sales Annex" is soliciting stock and will be until July 20, 2000. "We are looking for everything and anything from home-made jam to self-published books," says Perkins-Doyle.

People interested in submitting items for sales, should contact Perkins-Doyle by calling the Foundation at 203-315-2194.

The store will be set up as follows:

1. There is no fee to enter your work.
2. You must be current member of the Obsessive Compulsive Foundation to enter and, at the time of the conference to participate.
3. Please direct all questions to Patricia Perkins-Doyle at the Foundation.
4. To apply, send clear photographs of the work you want to sell (if visual art), samples of literature, and samples of audio or videotapes and CDs. These materials will not be returned so please do not send your only copies.
5. You do not have to be in attendance at the conference to have your work sold.
6. Fifteen percent of the sales after sales tax will be the fee paid to the OCF; the remaining amount will go to the artists.
7. Submissions for products will be accepted until July 20, 2000. ■

THE OCD WORKBOOK:

Your Guide To Breaking Free From Obsessive Compulsive Disorder

By: Bruce Hyman, Ph.D. and Cherry Pedrick, R.N.

Book Review
By Ian Osborn, M.D.
State College, PA

The OCD Workbook is the most helpful presentation of behavior therapy for OCD that has been published in quite a few years. Cherry Pedrick, an R.N who has herself suffered OCD, and Bruce Hyman, Ph.D., a psychologist and social worker who specializes in treating the disorder, make a great team. Their book flows smoothly along with a wonderfully compassionate tone while providing an excellent blend of clinical and theoretical material.

The book is divided into four sections. Part One presents an easily digestible review of OCD's diagnosis, proven causes, and effective treatments. Part Two, the heart of the book, discusses cognitive-behavior treatment in detail, including instructions for self-directed treatment programs. Part Three deals with OCD spectrum disorders and childhood problems. Part Four finishes with a discussion of how family members, support groups, and various types of therapists can help.

I found Part Two's presentation of behavior therapy to be exceptional. Clearly written, easy to follow, and yet very complete; it is the best introduction to behavior therapy for OCD that I have yet read. For every major subtype of disorder there is an outline for a complete therapy program.

Have a problem with "hit and run obsessions?" Pedrick and Hyman provide worksheets for assessing the symptoms, monitoring obsessions and compulsions, constructing a situations hierarchy, and then executing exposure and response prevention. All for that one specific problem and with examples of every form filled out! Likewise, step-by-step instructions are provided for the treatment of common contamination, harm, sexual, religious and orderliness obsessions. Pedrick and Hyman do not neglect the hard to treat cases. Pure obsessions, obsessional slowness, and hoarding are also tackled in an easy-to-understand manner with case studies included.

One of the main strengths of The OCD Workbook is the inclusion of a number of different approaches to behavior therapy. For those OCD sufferers who are "psyched up" to make an all-out effort, the book provides a "fast track." For those more fearful, there is a gradual method to follow that still gets results. Recently developed behavior therapy techniques including ritual delay and imaginal exposure are presented in a reader-friendly manner.

I particularly enjoyed the layout of the book. We do not have to wade through one lengthy paragraph after another. Rather, every page is divided into manageable sections with clear headings. Lists, highlights, sidebars, and set-off examples make the book ultra-easy to follow and a pleasure to read. A quibble is the lack of an index.

The OCD Workbook falls short only in trying to cover too much. Non-behavior treatments such as medications are dealt with superficially. Similarly, discussions of disorders that are associated with OCD such as depression, ADHD and Trichotillomania are not detailed enough to satisfy most readers.

All in all, The OCD Workbook is a wonderful addition to our resources. I am already using it with some of my patients. The discussion of behavior therapy is so clear and complete that it is equally helpful for both therapists conducting treatment and OCD sufferers taking on the disorder by themselves. ■

THE ANTIDEPRESSANT SOURCEBOOK

By: Andrew L. Morrison, M.D.

A review by Charles F. Schatz, M.D.

I recommend Dr. Morrison's book to patients being treated with antidepressant medications and to their families.

Above all, I find the book to be reassuring and informative. Reading this book or the sections which pertain to one's own situation can go a long way to reassure one that he or she is being treated appropriately and that there is real expectation for improvement. Similarly, it can help those who are not being treated appropriately and optimally to recognize this and seek a second opinion.

In addition, the book is a very informative guide for clinicians, both the prescribing physician and the therapist. None of these clinicians knows everything and most of them treat more than just your disorder. One can go a long way in improving one's own treatment by showing particular portions of this book which seem to pertain to one's case to the clinician. Discussing the particular sentences, paragraphs, or chapters which you think pertain to your situation will help you to learn more about your disorder and will help your clinician optimize your treatment. (This book is not a replacement for a clinician, but is a great adjunct for you and your treating professional.)

Uncertainty is one of the biggest challenges to overcome for the patient with OCD, other anxiety disorders, and/or depression. Dr. Morrision addresses uncertainty very well. First, he encourages clinicians to be open and honest with each patient, telling the patient his or her diagnosis and treatment plan. This, he points out, helps greatly to alleviate the patient's anxiety so that one's anxiety does not impede or delay one's recovery. Also, he provides patients and their family members with answers to many of the nagging, recurring, and anguishing questions that arise when one is suffering from OCD, other anxiety disorders, and/or depression.

The book provides a reference point against which to measure one's own therapy. It addresses common questions such as these:

1. Why should I expect a medication to help a disorder of the brain?
2. What should I expect from the medication?
3. Is this the right medication for me?
4. Might I do much better on a different medication?
5. What constitutes a fair trial of one medication so that I neither continue jumping from medicine to medicine without getting much improvement nor restrict myself to one medicine when another might help me considerably more?

Reading Dr. Morrison's book will likely help those suffering from other anxiety disorder, and/or depression to:

1. be encourage (to overcome pessimism)
2. understand the biochemical nature of one's disorder
3. be compassionate toward oneself
4. see taking medication as appropriate treatment and not a sign of mental weakness (have permission to be on medication)
5. establish reasonable expectations including reasonable time frames
6. remain patient while allowing the medication and therapy to combine to bring significant relief
7. be reassured that he or she is being treated appropriately and optimally

The book educates and is a "very friendly read." The author includes numerous "Case Examples" which make reading this book a personal experience and illustrate the individuality of diagnosis and response from case to case. ■

OCD NEWSLETTER

The OCD Newsletter is published six times a year.

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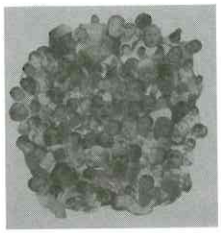
The Obsessive Compulsive Foundation (OCF) is an international not-for-profit advocacy organization with more than 11,000 members worldwide. Its mission is to increase research, treatment and the understanding of obsessive-compulsive disorder (OCD). In addition to its bi-monthly newsletter, OCF resources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

CHAOS



A MOTHER'S VIEW OF OCD

CONFERENCE ART SHOW – "ART AS A LIFELINE"

There will be an Art Show again this year at the Seventh Annual OC Foundation Conference, August 11-13, 2000, at the Hyatt Regency Hotel Woodfield in Schaumburg, Illinois.

The theme is "Art is A Lifeline." The Foundation is looking for submissions that express how the act of creating art is a lifeline to someone suffering with OCD. This is true for the viewer as well as the artist.

Anyone of any age, who is a member of the OC Foundation and attends the Annual Conference, can submit up to three pieces, utilizing any visual medium.

A color photograph of the piece must be sent to the OC Foundation in North Branford, CT, with the dimensions of the work described on the back. If your work is selected, you will be notified in writing. None of the photographs will be returned.

For further information about the Art Show, contact Jeannette Cole at 203-315-2190 or e-mail her at cole@ocfoundation.org. ■

REVISED SOCIAL SECURITY LAWS HELP DISABLED RETURN TO WORK

The President signed into law some extremely important legislation on December 17, 1999, revisions to the Social Security Disability Benefits laws that impact on everyone who has a disability. The law is entitled Ticket to Work and Work Incentives Improvement Act of 1999. These changes have given new opportunity to people who want to go back to work or enter the workforce, but don't want to lose their medical coverage or lose their eligibility for disability benefits if they have a relapse.

Public Law 106-170 expands the time in which a person who has been on disability benefits can continue to receive medial coverage under Medicare after her/she returns to work. With the passage and signing of the bill, recipients of social security disability benefits can continue to be eligible for Medicare benefits up to 8½ years after returning to work. Another significant provision of the

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Member to Member Lifelines – Poetry

MONKEY

By K. Pagacz

Discomfort wriggles all over my body.
Something is wrong inside of my head.
I am uncomfortable.
For me to have my comfort, I must solve the unsolvable riddles.

"Come here I have what's bothering you" says, Monkey.
Monkey like a circus chimp, wears a glittery red vest.
"Step right up, step right up." Monkey is so seductive.
I can feel myself being seduced, almost entranced.

When I give him attention, he becomes stronger, I become weaker.
Monkey promises that if I play his games, I'll have my freedom and peace of mind.
He explains in very simple terms, that for me to reach the comfortable feeling that I crave, I need to solve his riddles.
I choose to listen to Monkey

Monkey presents the most convincing illusions.
His eyes are blazed.
I follow Monkey into a dark hole inside my psyche.
We awaken at his favorite tormenting spot - the Game Room.

Each game starts with an unsolvable riddle.
Red lights flash across my face and sirens and alarms go off.
On one wall Monkey shows me a slide show of dark and frightening images.
He says, "If you want your freedom and relief just answer this riddle and relief will be yours."

He tells me that my answers are at the gopher game.
I shutter and hear constant clamoring in my head.
His game room is filled with so many distractions.
I feel like I need to achieve resolution.

Monkey explains, "Once you win this very simple and easy game, and solve the riddle, you will be free - peace of mind will be yours."
Tokens for the games appear in my sweaty and wrinkled pocket.
I continue to believe Monkey.
I am in anguish.

I want nothing more than to solve each riddle.
Monkey's offer of my freedom is irresistible.
I crave riddle resolution like a junkie craves a heroin fix.
I give my token to Monkey and my thoughts begin to whip around; all straight lines are gone.

Monkey hands me a wooden mallet as the gophers pop up from their holes.
They're holding signs that have messages of things that I am afraid of.
I want the messages to go away.
The only way to keep the gophers and their messages away is to hit them with my mallet.

Lights flash and alarms sound and I am challenged.
The gopher signs are so ripping.
Each one taunts and tortures me.
One message says, "You wrote a bad note!

You have consequences to pay!", the other message says, "You will die, because someone is going to come after you!"
I want to hit the gophers with my mallet and drive them into their holes.
Each message is like a riddle that gets stickier and the gophers multiply quickly.
My coordination is off.

I am off balance.
I swing my mallet, spending all of my energy and I am out of control.
I am sweaty.
I am panicky - completely overwhelmed and anxious.

Red lights flash across my face.
I must leave this Game Room, but I am compelled to stay and play the game.
The room is spinning and the exit door has disappeared.
The gophers continue to pop up with all of their horrible messages and hideous reminders.

Monkey continues to chant and speak in riddles and he chatters and chatters into the deepest hollow of my head.
I keep playing because I want relief.
Monkey is laughing and chattering.
He has so much fun seeing me tortured.

And he keeps repeating the riddle in his high pitched voice.
My mind feels blurry.
Each riddle is personalized for me.
I pick up my mallet again.

I am crying and my breath feels completely hallow.
I hear chilling echoes in my mind.
I am afraid and lost and my brain feels like it is being pinched.
I want relief.

I want comfort.
I want the riddle solved.
I don't understand Monkey's questions and I don't have any answers.
I am exhausted, but still determined to solve the unsolvable riddle.

I am confused and in great pain.
The alarms keep sounding and my head throbs.
And I play and I cry and I play and I cry.
I believe the riddles - bad things are going to happen to me!

My breaths are short and quick.
My soul rips as my mallet swings out of control.
I want it all to stop.
I am weak.

I have been robbed of all my luster, my strength and my time.
I feel like something is lodged into my brain.
Clear thoughts are cut off.
Because I can't solve the riddle, I can't have any rest.

I feel like an electrical circuit board in the middle of a lightning storm.
I am tortured and the Game Room is my torture chamber.
The riddle haunts my mind.
It is repetitive.

I want to solve it.
Nothing else matters.
I am fully consumed.
I want to take the Monkey chatter out of my mind.

I am falling deeper and deeper and I am afraid.
I want it all to stop.
Please, Monkey, stop!

I scream through a hundred centuries and no one seems to hear me.

I am hopeless.
What can I do to help myself get out of his clutches?
I want to feel right.
I want a nice long vein injection of reassurance and resolution.

I want to know that everything is okay.
I want to shut it all off.
To find the plug and pull it out of the wall.
Monkey takes out his brass symbols and smashes them together.

The clanging noise charges into my spine.
The gophers keep popping up.
I want silence.
I want to shut it all off; I am like a fly stuck in glue. ■

Bazelon Center for Mental Health Law Explains How the ADA Applies to People with Psychiatric Disabilities

The Equal Employment Opportunity Commission (EEOC) has released a policy guidance concerning application of the Americans with Disabilities Act to individuals with psychiatric disabilities. The comprehensive document answers some of the most common questions about psychiatric disabilities and the ADA.

The new guidance should be helpful to consumers, advocates and employers alike. It discusses how to determine whether a condition is covered under ADA, disclosure of a disability, requesting reasonable accommodations, examples of reasonable accommodations, when an employer can discipline a worker for misconduct resulting from a disability, direct threat and professional licensing.

A guidance is an addition to the EEOC compliance manual and is used by the agency's investigators in determined whether a complainant's ADA rights have been violated. Although EEOC guidances are not regulations, they can inform courts about the official position of the agency responsible for ADA enforcement in the employment area.

Several of the EEOC positions in the new guidance are especially important to consumers and advocates:

•The guidance expands the list of major life activities to include those relevant to psychiatric disability. An employee wishing to establish that he or she has a covered disability must show substantial limitation of a major life activity. The guidance includes such activities as "learning, thinking, concentrating, interacting with others, caring for oneself, speaking, performing manual tasks, or working. Sleeping is also a major life activity …." This expansion should enable people with psychiatric disabilities to get past the first hurdle under the ADA: whether the employee has a covered disability.

•The EEOC reiterates its position that the corrective effects of medication should not be considered when deciding whether an impairment substantially limits a major life activity. Several courts have disagreed with this position, but the EEOC has held firm. This is very important to consumers taking medications that alleviate their symptoms, but not their need for an accommodation.

•The agency affirms that "chronic, episodic conditions may constitute substantially limiting impairments if they are substantially limiting when active or have a high likelihood or recurrence in substantially limiting forms." The guidance mentions bipolar disorder, major depression and schizophrenia as examples of disabilities that may be episodic over the course of months or years. Accordingly, even if a disability is not currently active, an employee who needs an accommodation to continue controlling symptoms can be covered by the ADA.

•The guidance again notes that an employer cannot ask a job applicant whether he or she has a disability or needs a reasonable accommodation. This is a particularly useful protection for people with disabilities that are not visible.

•The Commission clarifies that an employer requesting information from an employee seeking an accommodation may only ask for information that is necessary to verify the existence of a disability and the need for accommodation. This provision means an employee or applicant may refuse broad employer requests, such as for all of a consumer's therapy notes. However, employees should be aware that the guidance allows the employer to insist that the employee see a professional of the employer's choice if the initial information given the employer is insufficient to prove that the employee has a disability and needs an accommodation.

•The EEOC also takes the position that an employee can use plain English to request an accommodation and need not use the specific terms "reasonable accommodation" and "ADA." This should make it easier for employees who are not familiar with the legal terms.

•The guidance gives several examples of potential accommodations, including modifications to work schedules or policies, physical changes to the workplace, adjusting supervisory methods, providing a job coach, and reassignment to a different position. The guidance also makes clear that medication monitoring is not a reasonable accommodations, so employees cannot be forced to take medication under the employer's directive.

•Importantly, the guidance provides that an employer can only discipline an employee with a disability for misconduct related to the disability if the workplace standard is job-related to the employee's position and consistent with business necessity. If the misconduct has no relation to the person's ability to do the job in question, the employee cannot be disciplined.

This article was taken with permission from the web page of the Bazelon Center for Mental Health Law at bazelon@tidalwave.net.

Mimicking OCD

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James is very anxious, and feels that he is the fault of his treatment failure. Oddly, in session, he is easily distracted by my questions and stops his OCD behavior to pay attention. This was my first clue that there might be an unusual type of OCD present.

James was brought to me by his parent who is seeking an alternative treatment due to James' failure with cognitive-behavioral work. In the first evaluative meetings, James demonstrated clearly that he had an extremely high score on the YBOC. He is primarily a washer with germ phobias, but seems to also have every other type of obsession and compulsion on the list.

After completing the YBOC exam, I asked the adolescent and his father if:

1. Is the person failing current treatment?
2. Is there a family history of bipolar disorder?
3. Are there periods of depression and mania/hypomania?
4. Are the OCD issues almost psychotic?
5. Are other psychotic thoughts present?
6. Is the person aware of mood shifts?
7. Did an antipsychotic medication work, alluding to the presence of bipolar disorder?
8. Did an antidepressant start a mania /hypomania?
9. Is the response to the medication one of lessening benefit?
10. Has the person been misdiagnosed with many other disorders, including panic, thought disorder, or attention problems?
11. Has the doctor attempted to respond to the patient's needs at each meeting by adding medications that are just "patches" for the holes: i.e., has the doctor added tranquilizers, antipsychotics, or energizing antidepressants in response to symptoms that are really bipolar swings: the bipolar person may have mood, anxiety, or energy swings every few minutes, hours, or up to months?
12. Does the person sense something in their moods, or even in their head ("its shifts, it clicks, it feels weird")?
13. Does the person sense shifts in mood not associated with stimuli?
14. Does the person seem anxious, panicky, hyper or agitated?
15. Does the person have less a sense of "ego alien" regarding the OCD?
16. Are memories, flashbacks, or horrific images extremely predominate.

After reevaluation, I met with James' doctor and asked that a bipolar medication be tried. The individual responded to the medication and mood swings and bizarre thoughts were dramatically reduced in four weeks. The gains continue to be simply great. At this time, it is easier to give James a clear diagnosis: bipolar

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ERP – A Lifeline – Very Helpful for Children! Parents' Role is Pivotal

By: Christina J. Taylor, Ph.D., Sacred Heart University, Bridgeport, CT

Exposure and Responsive Prevention (ERP) can be very effective in treating children with Obsessive Compulsive Disorder (OCD).

Christina J. Taylor, Ph.D. Behavior Therapist, presents us with a most encouraging case report of such a success. She tells of a pre-teen girl with moderate to severe symptoms who has been able to overcome these symptoms and very importantly has maintained this improvement over a three year period. In this case, the young girl was troubled by obsessional concerns related to contamination and had become deeply entrenched in compulsive washing rituals and avoidance.

Dr. Taylor shares many insights from which OCD sufferers and family members can draw encouragement:

1. *children with OCD can and do benefit greatly from behavior therapy.*
2. *children with contamination obsessions and rituals of hand-washing and avoiding can and do benefit greatly from behavior therapy.*
3. *the child's personal determination to overcome her obsessions and compulsions contributes greatly to success.*
4. *the child's determination increases during the course of treatment.*
5. *parents can contribute greatly to their child's success by:*
   a. *determination*
   b. *patience*
   c. *perseverance*
   d. *willingness to model the ERP exercises which are scary to the child*
   e. *willingness to carry out ERP at home*
   f. *willingness to work through the ERP as a team*
   g. *being trusted by the child*
6. *intensive short-term therapy can be very effective*

This young girl's treatment consisted of 12 months of twice-a-month behavior therapy sessions followed by an intensive 3 week ERP program at home. This scholarly, journal-like article by Dr. Taylor points out not only the importance of the behavior therapist in managing treatment. It also clearly describes the important roles played by the child herself, the parent(s), and even the siblings in leaving Mom and daughter alone for the first week of intensive ERP. Dr. Taylor's report ought to be a great encouragement to the families of children who are challenged with the frustrating, annoying, seemingly unbreakable pattern of obsessional worries and compulsive rituals.

The clinical issues which can make administration of Exposure and Response Prevention (ERP) therapy for Obsessive Compulsive Disorder difficult with adults certainly also affect the treatment of children including family cooperation and assistance, patient motivation, the allotment of time, and financial costs. Some of these therapeutic issues can be magnified further when carrying out intensive Exposure and Response Prevention on a daily basis over a period of two to three weeks. One way to facilitate administering such treatment is to enlist parents to carry out exposure and response prevention exercises at home. This case study provides a description of a treatment regimen in which a mother worked with her 12 year old daughter to help alleviate obsessive compulsive symptoms involving contamination fears and compulsive washing.

History

Marie received a diagnosis of OCD when she was 9 years of age. Concerns about germs and cleanliness had appeared briefly at 7 years of age following an incident at a school health fair in which children held their hands under UV light to examine the germs remaining after washing. Excessive washing lasted approximately two months, then disappeared. At 9 years of age (third grade), Marie developed obsessions about spit from boys or men and resumed compulsive washing. Washing was carried out to remove the feeling that the person who spit was perceived as attracted to Marie, and the residue of the spit left an uncomfortable feeling associated with this attraction. These obsessions and the distress associated with them worsened as the obsessional content became more and more concerned with sexual fears. Avoidance behaviors emerged involving keeping hands tucked inside sleeves when in public places and crowds. Marie compulsively licked her fingers as a means of removing the negative feelings. At this point mother and child were both caught in a frustrating cycle of reassurance seeking which necessitated an attempt to shift more parenting responsibilities to Marie's father. In mother's words, mother and child were enmeshed in a tense and conflict ridden relationship. The OCD symptoms waned at the start of fourth grade but reemerged later in the fall. Marie and her family subsequently sought behavior therapy.

Treatment

Initial assessment of Marie's OCD on the Children's Yale-Brown Obsessive Compulsive Scale indicated that the symptoms severity fell in the moderate to severe range. Marie herself appeared to be a very bright, talkative, social and inquisitive child, who loved sports and animals, and who was frustrated and angered by the obsessive compulsive symptoms. The anger was most pointedly directed at her mother and Marie's occasional angry outbursts were a source of particular distress to her mother. It was clear that both mother and child needed an intervention to relieve the situation.

An anxiety hierarchy was constructed identifying the sources of contamination or "cootie" things that triggered washing or avoidance. A contingency management system was designed which linked Exposure and Response exercises to earning points which could be traded for money. Marie is a child who has a true connoisseur's appreciation for candy and sweets, so in-session exposures were carried out with these rewards as incentives. The points earned carrying out exposure assignments at home were traded to make purchases of candy, rent videos, etc.

Marie was initially very resistant to performing in-session exposure exercises despite all the incentives provided. Systematic modeling of exercises by mother, warm hugs and comforting laps helped soothe the anxiety from exposure exercises. Mother and therapist engaged in lots of coaxing and with encouraging perseverance Marie made steady, step by step progress over a period of 25 sessions carried out over 12 months.

During the year of therapy, modifications were made to the treatment as situations and objects were added to and subtracted from the hierarchy. Family sessions were held and one home therapy session was done. The possibility of SSRI medication was periodically discussed. Adjunctive tools to help cope with the anxiety produced by the exposure exercises were taught, including cognitive restructuring, delaying, postponing, relaxation, and distraction.

Fortuitously, for exposures involving touching body parts, the Macarena became popular so that dancing the Macarena made for a more light hearted approach to very anxiety producing exposure exercises.

Mother and child negotiated a behavioral contract to address angry and resistant behavior. Two months following this contract, we reviewed the progress made to date to accommodate for and devised a plan for carrying out an intensive program of ERP.

We planned to start the intensive ERP the week of Marie's school vacation. It was agreed that there would be very limited washing during this week and only slightly more during the second and third weeks which followed. One hour of ERP would be sys-

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ERP – A Lifeline

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tematically carried out each day. Marie's motivation to engage in intensive flooding appeared to spring primarily from the prospect of ending therapy and its attendant unpleasantries (negative reinforcement).

During the regimen, the usual points, candies, and treats were to be used as immediate reinforcers. The week of ERP began on the first Saturday of vacation following a soccer game and a shower afterwards. From that time no washing was allowed until eight days later, the following Sunday night. Both mother and daughter were to follow the plan. As it turned out, the soccer game was rained out, showers were taken in the afternoon and the regimen began.

The first day was the most difficult, according to both mother and child. Planned daily activities to get out of the house during the week seemed to help. Marie was able to wash her face each morning by dipping it in a sink filled with water and thereby not using her hands. Complaining time was scheduled for each day but used only occasionally because the anxiety was less than expected.

As explained by mother, "It was as though we had a shared goal and a certain camaraderie developed around this challenge." At mid-week an office therapy session was held and we agreed at that time that handiwipes could be used if Marie's hands got sticky. As it turned out, Marie used them only once or twice.

Response prevention following soccer practice on Friday was somewhat difficult but Marie wiped off sweat and grime with a dry towel. On Saturday when the rest of the family returned from a trip, Dad took over for the weekend while Mom went to take a day long exam. Dad also engaged in the response prevention surrounding washing and cleaning. Following church on Sunday, the whole family went with Marie for the purchase of roller blades - the planned reward for a successful week of intensive ERP.

At the conclusion of three weeks of intensive ERP, the anxiety levels associated with items in the hierarchy were all reduced to low levels and compulsive handwashing and avoidance were greatly improved. The CY-BOCS score placed the obsessions and compulsions in the sub-clinical range and this improvement has been maintained after three years. A variety of factors contributed to Marie's success in gaining control over her obsessive compulsive symptoms, including her personal resources and motivation as well as those of her family.

In the latter case, Marie's mother's perseverance, courage, fortitude and patience were key to the efficacious effects of the behavior therapy as it was carried out over the course of the long, as well as the short, intensive regimen. In particular, it became evident during the initial in-sessions exposure exercises that mother's modeling of the exercises was very critical to Marie in her willingness to carry out an exercise and to tolerate high anxiety levels. The ability to capitalize on the child's trust of her parent thus enabled progress toward this very successful treatment. ■

Sign Up Now For Summer Camp

The Greater Boston Affiliate of the OCF, in conjunction with the OCD Institute, is sponsoring a co-ed residential summer camp for children with a previous diagnosis of OCD. Camp Hope, which will be held August 19 to 31, in Duxbury, MA, offers an environment where children can meet and socialize with their peers. The camp offers a wide variety of activities including water sports, athletics, nature walks, arts and crafts and a rope course. Professional staff will work with the children in order to provide education about OCD and lead support groups. Staff, who will be living with and supervising the campers, have been trained to assist the participants in managing their symptoms in order for them to take full advantage of all the activities which the camp offers.

The camp will enroll children between the ages of 8-12 who will have successfully completed school grades 4-8 during the 1999-2000 academic year. Camp Hope's specialized program will primarily focus upon recreation, socialization and participation in support groups. The admission criteria and applications can be found in the camp's brochure which will be forwarded to you upon request. Please call Judie Beshwaty at 617-855-3371; email beshwaty@ocd.mclean.org or fax 617-855-2583.

Applications for staff positions are available at the above contact numbers. ■

The OCF Annual Meeting Sure Helped Me!

By: Charles Schatz, M.D.

What a great experience! I recommend it highly! What? Attending the Obsessive Compulsive Foundation Annual Conference!

In the summer of 1999, doing "o.k. but not great" with my Obsessive Compulsive Disorder of 27 years duration, I took a chance and attended the annual conference.

Anxiety! Ill at ease! The first day did not go too well. It was not very encouraging at all!

But!..... By the end of the weekend, I would not have traded the experience for anything. I was eager to put what I had learned into practice. I was truly hopeful that what I had learned would help. And I was eager for next year's annual meeting.

What turned this around? Start with 700 people all but 60 of whom are fellow OCD sufferers and their immediate family. The other 60 are the expert presenters, OCF staff, and OCD caregivers.

Add being located in a hotel which is hosting other conferences at the same time. Notice that, as the weekend progresses, you cannot tell the OCD conference attendees from the corporate conference attendees from the tourists.

Talk to fellow OCDers during coffee breaks. Hear some stories that are incredibly akin to your; worse than yours; milder than yours. Feel comforted. Feel worse for someone else than you do about yourself. Find yourself feeling happy for those whose OCD is not as severe as yours. Be encourage by the gains your fellow OCDers have been able to make.

Feel anything but alone with your OCD. Choose workshops to attend. Gain insights. And find that the expert presenters are available and very approachable after their talks and between sessions. Learn from the formal presentations, from other people's questions, and from you own one-on-one talks with these experts.

My specifics: I approached a few of the expert presenters and heard the same thing. I was told that, having gained much from medication and behavior therapy, I'd now be greatly benefited by cognitive therapy.

After the conference, I pursued it. And cognitive therapy has helped immensely!

And I'm headed back this year to the annual conference. Why? To be helped further, to mix and share with others, and hopefully to be of assistance and encouragement to others.

It took a lot of courage and encouragement from others for me to attend my first annual meeting last summer. Now I cannot wait for my second.

Are you doing "o.k. but not great?"...or worse? Have you made some gains but are now on a less-than-satisfying plateau? There's a very good chance this conference will be of great help.

I encourage you to attend. Get yourself to the OCF Annual Conference, August 11-13, 2000, at the Hyatt Regency Woodfield just outside Chicago. Bring a family member /support person or come alone, for you will not be alone at all. ■

OCD and Parenting

Without a doubt, parenting is filled with gloriously rewarding and fulfilling experiences. Parenting also contains stress, doubt and worry. The decision to have children and how to raise them to the best of a parent's ability is one worth deep consideration, especially when the parent has OCD. For a parent with OCD, he or she has the additional concern of how to cope with the impact of the disorder on his or her parenting and the children.

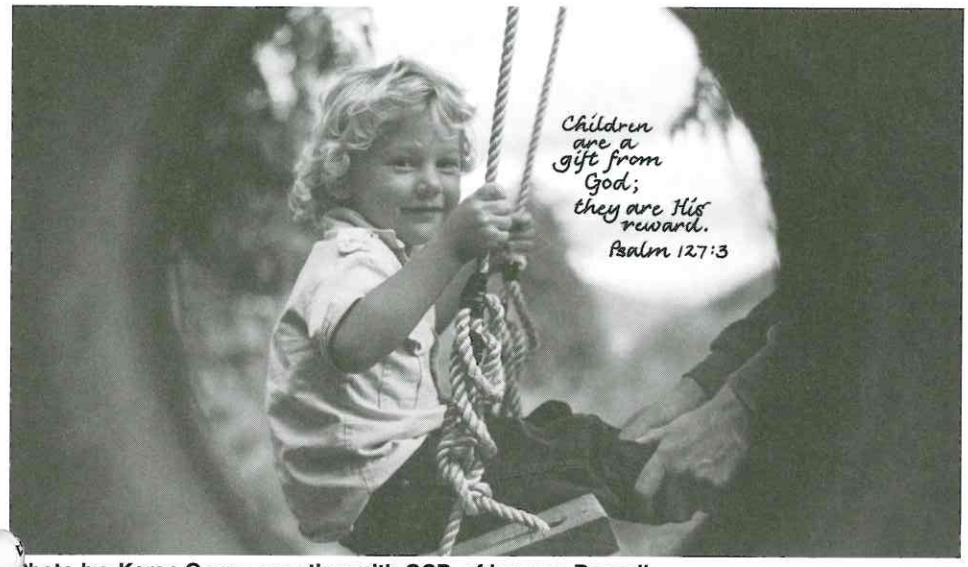

Photo by: Karen Grove, a mother with OCD, of her son Russell

Commissioned by the OCF, Hugh F. Johnston, M.D. and J. Jay Fruehling, M.L.S. created an informative and easy-to-use guide for parents or prospective parents to address the critical issues and topics about the possible impact of parental OCD on children. The following are selections from the guide. The entire guide, which includes additional sections, is available through the Foundation.

How might OCD affect the decision to have children?

The presence of OCD (or any other illness) ... raises several concerns: (1) the risk of bringing a child into the world who will later be troubled by OCD, (2) the capacity of the parent's OCD to interfere with child rearing, (3) in the case of a mother with OCD, issues surrounding pregnancy and breast-feeding, and (4) the possibility that the addition of a child to the family will worsen the parent's OCD Symptoms.

What are the chances that my child will inherit OCD?

There appears little doubt that OCD often runs in families. However, it appears that genes are only partially responsible for causing the disorder... Some experts have speculated that there may be different types of OCD, and that some are inherited while other types are not... If one parent has OCD, the likelihood that the child will be affected is about 2 to 8 percent.

Will pregnancy affect my OCD?

It might. It has been widely recognized for many years that OCD may worsen during pregnancy. We typically advise the mother against taking anti-OCD medications during pregnancy.*

What about taking anti-OCD drugs while I am pregnant?

The issue of whether or not anti-OCD medications should be taken during pregnancy is quite controversial, and it can arouse passionate and irrational emotions in both patients and their doctors. This is an issue that each prospective mother must consider with her psychiatrist and obstetrian. Only with a doctor's guidance can decisions about medications be made.

What if the mother becomes depressed?

Many women experience "postpartum blues." This is usually a relatively brief period (about one week) during which the new mother may feel sad, weepy, and overwhelmed. Typically, these symptoms are mild, and no treatment is required. However, in our clinical experience, women with OCD seem more susceptible to developing postpartum blues, and these blues often appear to be more severe. Because of this, it is important to have emotional support and practical help available to the mother after the baby is delivered.

If the depressed new mother is not taking anti-OCD medications, this may be a good reason to start. All anti-OCD medications are also effective antidepressants, and they may improve both OCD and mood symptoms.

Can someone have OCD and still be a competent parent?

Yes, except in very severe cases. Most of the time, OCD has very little direct impact on parenting, especially when effectively treated. Often, children are completely unaware that their parent is struggling against OCD symptoms.

When severe, OCD can drain a parent's time and energy to a degree that his or her ability to meet the needs of the child is reduced. Also, many people with OCD suffer bouts of depression. In our experience, the episodes of depression have a much greater impact on parenting ability than the OCD. If can be very helpful if parents (especially single parents) develop a support network of family and friends who can "pitch in" should the OCD worsen or a depression develop.

What should parents with OCD tell their children about the OCD?

Provide an open atmosphere in which your child is comfortable asking questions. And then let the child's questions guide you... Try to understand why a child would like to know more information about OCD... Remember that your explanations have to be geared to the child's vocabulary and level of understanding... Always tell children that medications should not be taken by anyone except the person for whom they are prescribed.

What if my obsessions/compulsions involve my children?

This a fairly common occurrence and can take a variety of forms the obsessions are most often related to harm coming to the child, and can include fear that an infant is smothering, terror that a child has been sexually abused, worry that the child has been exposed to toxins (often lead), or just a general uneasy sensation that something regarding the child is wrong. These obsessions can become very painful, particularly if the parents are obsessed that they themselves have smothered or otherwise harmed their child in some way. Another painful twist on these themes occurs when a parent becomes obsessed with fears and doubts that a spouse or partner has harmed the child. This can strain even the most solid marriage.

These obsessions typically lead to compulsions that involve checking activities. Parents with these OCD symptoms might check on their children numerous times at night to ensure that they are okay, or repeatedly check on them as they plan throughout the day. Also, washing rituals and elaborate food preparation rituals can emerge in an effort to prevent contamination. The severity of these ranges from a minor annoyance to a major disruption in day-to-day life.

Usually, the help of the trained behavior therapist is very useful, although parents who have already had some experience with behavior therapy can often design their own program.

Can parenting styles or techniques affect the development of OCD in children who are "at risk"?

Yes and no. We strongly doubt that there is any parenting style that will fully prevent OCD symptoms from occurring in a child vulnerable to developing OCD. Similarly, even the worst parenting possible does not seem to produce OCD. However, it does appear that if a child develops OCD or OCD-like symptoms, parenting techniques

Continued on page 11

Would you like to submit an article for the next newsletter? Deadline: June 2, 2000

** However, this is a choice that each prospective mother must make with the advice of her treating physicians*

Research Digest

Article reprints may be obtained from the OCD Foundation for $3.00 per copy for shipping and handling. These articles and additional information on the latest research on OCD and related disorders, may also be obtained from the Obsessive Compulsive Information Center, Madison Institute of Medicine, 7617 Mineral Point Road, Suite 300, Madison, WI 53717, (608)827-2470.

Selected and abstracted by Bette Hartley, M.L.S. and John H. Greist, M.D. Madison Institute of Medicine. The following is a selection of the latest research articles on OCD and related disorders in current scientific journals.

Cognitive-behavioral therapy as an adjunct to serotonin reuptake inhibitors in obsessive-compulsive disorder: an open trial

Journal of Clinical Psychiatry, 60:584-590, 1999, H.B. Simpson, K.S. Gorfinkle and M.R. Liebowitz

This small open trial of 6 patients suggest that cognitive-behavioral therapy (CBT), using exposure and ritual prevention, can lead to a significant reduction in OCD symptoms in patients who remain symptomatic despite an adequate trial of a selective serotonin reuptake inhibitor (SSRI). While taking a stable dose of an SSRI and having been on the medication for 12 weeks or longer, patients received 17 session of exposure and ritual prevention. All patients improved significantly with a mean Yale-Brown Obsessive Compulsive Scale decrease of 11.6 points. Study results were based on a small sample of patients who were motivated to try this therapy. Whether all OCD patients who respond only partially to SSRI medication can gain additional benefit from CBT is unclear.

Is episodic obsessive compulsive disorder bipolar? A report of four cases

Journal of Affective Disorders, 56:61-66, 1999, C.M. Swartz and W.W. Shen

Lithium and electroconvulsive therapy (ECT) were effective treatments in four unusual cases of OCD which had not responded to tricyclic or SSRI antidepressants. Lithium and ECT are rarely effective for patients with typical OCD, but in these case reports, episodic OCD appeared to be manic symptoms of bipolar disorder. The onset of the OCD was acute and appeared at an older than expected age (range 32-55 years). These four cases suggest s syndrome of OCD symptoms, which appears suddenly at an older age, and may be an expression of bipolar disorder and may respond to lithium, ECT, or other effective treatment of bipolar disorder.

Multicenter double-blind comparison of sertraline and desipramine for concurrent obsessive-compulsive and major depressive disorders

Archives of General Psychiatry, 57:76-82, 2000, R. Hoehn-Saric, P. Ninan, D.W. Black et al

This multicenter trial, with one hundred and sixty-six patients, is the first comparison of an SSRI (selective serotonin reuptake inhibitor) and a non-SSRI antidepressant in the treatment of OCD with concurrent major depressive disorder (MDD). Sertraline (Zoloft) was more effective than desipramine (Norpramin) for both OCD and depressive symptoms. Studies show a high co-occurrence of MDD, ranging from 30% to 60%, for individuals with OCD. It has been suggested that patients with both OCD and a depressive disorder may be less responsive to treatment. This study is of interest because there was a favorable OCD response to sertraline (Zoloft), similar to the response shown for OCD patients without major depression.

Obsessive-compulsive disorder and anorexia nervosa in a high school athlete: a case report

Journal of Athletic Training, 34:375-378, 1999, R.L. Gee and N. Telew

This is a case report of an adolescent athlete who exercised compulsively outside of her athletic program and dieted to the point of starvation. Her OCD was not recognized while she was under lengthy treatment for anorexia nervosa, and there was a dramatic recovery of both her OCD and anorexia nervosa following the recognition and subsequent treatment of her OCD. A combination of cognitive-behavior therapy and fluoxetine (Prozac) was used. OCD occurs frequently in patients with anorexia, and successful management requires that both conditions be identified and treated.

A placebo-controlled trial of cognitive-behavioral therapy and clomipramine in trichotillomania

Journal of Clinical Psychiatry, 61:47-50, 2000, P.T. Nina, B.O. Rothbaum, F.A. Marsteller et al

Cognitive-behavior therapy (CBT) with habit reversal and serotonin reuptake inhibitors such as clomipramine (Anafranil) are reported to be effective treatments for trichotillomania. This study compared CBT and clomipramine in a 9-week, placebo-controlled, trial. CBT has a dramatic effect in reducing symptoms of trichotillomania and was significantly more effective than clomipramine. Clomipramine resulted in symptom reduction greater than placebo, but the difference fell short of statistical significance.

Recent life events and obsessive-compulsive disorder (OCD): the role of pregnancy/delivery

Psychiatry Research, 89:49-58, 1999, G. Maina, U. Alpert, F. Bogetto et al.

Conflicting results have been reported on the possible role of stressful life events or trauma in triggering OCD onset. This study investigated life events that occur prior to the onset of OCD, with particular attention to pregnancy and postpartum effects. Results of this study did not show a significant increase in the number of life events in patients who develop OCD in the 12 months or the 6 months before onset of OCD. Also the study did not find an association between pregnancy and the onset of OCD, but did confirm the high rate of postpartum OCD. Findings suggest that postpartum OCD may be associated with caesarean section without labor and to pre- and post-term childbirth, but these date need to be confirmed by further study.

Strategic processing and episodic memory impairment in obsessive compulsive disorder

Neuropsychology, 14:141-151, 2000, C.R. Savage, T. Deckersbach, S. Wilhelm et al

This study examined verbal and nonverbal memory performance in 33 OCD patients and 30 normal controls. OCD patients showed impaired recall on both verbal and nonverbal memory tests. Specifically, they used less systematic organizational strategies in the memory tests. Information processing skills may cause these memory problems in OCD. It is possible that disruptions in memory contribute to some clinical symptoms of OCD, such as chronic doubt and repetitive behaviors. On the basis of these findings, the researchers are currently investigating the effectiveness of cognitive retraining approaches for OCD, in which patients are taught to use more effective memory encoding and retrieval strategies.

The stress of caring for people with obsessive compulsive disorder

Community Mental Health Journal, 35:443-450, 1999, T.M. Laidlaw, I.R.H. Falloon, D. Barnfather et al.

Findings from this survey of key caregivers of patients with OCD show that 28% of caregivers were severely burdened by their career role and 25% were extremely distressed at the prospect of ongoing care provision. Caregivers particularly felt the OCD affected their marital relationships and home management. These results indicate that caregivers, and probably others in the family, need substantial support. Appropriate stress reduction interventions for careers including education and cognitive-behavioral strategies could be combined with the patient's treatment program, although such strategies have yet to be evaluated for their helpfulness. ■

From the Foundation

Continued from page 1

A teckie from another company finally found the problem with the software. He was mumbling something about "automatic defaults" and "tracing." Sara has demolished the wall of envelopes that filled her room feeding in names, addresses, phone numbers. Hannah has extracted this information to send Newsletters, information packets, renewal letter and new member packets on their way. Expect your's soon.

Everyone is working on the Seventh Annual Conference, which is scheduled for August 11-13, 2000 at the Hyatt Regency Woodfield in Schaumburg, IL. This is a suburb of Chicago, seven miles from O'Hare airport. Scott Rauch, M.D., is taking us into the 21st century with this keynote presentation on the neurobiology of OCD.

There are going to be over 50 separate presentations this year. That is why we are starting on Friday morning instead of Friday afternoon. Subject matter ranges from the latest on medication to yogic meditation. There are workshops on herbal remedies, Obsessive Compulsive Personality Disorder, Compulsive Gambling, Intensive Behavior Therapy, changes in the Social Security laws, Psychiatric Rehabilitation, GAD and Panic, just to name a few. The registration brochure should be arriving shortly because the machines that send it to you are working well again.

There are special tracks for parents, children and adolescents and young adults with programs on Exposure and Responsive Therapy, medications, school accommodations, impact on the family and available resources. There is a video-making program and art programs for children and younger teens; a screenplay workshop led by the writer for older teens and young adults.

There will be a wider range of support groups including one led by parents for parents and a support group for young adults led by a young man with OCD, who will be going to graduate school in the fall along with G.O.A.L. and OCA groups. And, one for the kids with the support of therapists.

There is also going to be a G.O.A.L. Virtual Camping Trip on Friday night and Saturday morning. And, a non-shopping spree at the Woodfield Mall lead by Drs. Gail Steketee and Randy Frost.

We are not videotaping this year. When measured by our new yardstick - cost effectiveness - it didn't survive the cut. There will be some audiotaping.

This year we want to expand the Art Show. People with OCD have so much talent and we want the world to know it. Contact Jeannette Cole about any ideas you have or if you want to be in it.

Daisy will be running the bookstore and we're working on stealing some of her space for a boutique featuring products made by people with OCD.

An addition to "Ask the Experts" is "Ask the Insurance Maven" featuring Diane Baney, RW, MBA from the OCD Institute.

Hannah's completely revising the Support Group Manual with more information and resources. Daisy has just sent the revised Publications Lists to the printer with the latest books and videos. There's also a revision of the OCD and Medication pamphlet in the works.

One more thing, and I need everyone's help on this. The above-mentioned vendor problems got me thinking about economic interest circles. I think that the OCF should initiate one. With medications and behavior therapy, the changes in the Social Security laws and the ADA, all of us, people with OCD, have a better chance to survive and thrive in the job world. Wouldn't it be nice if we helped each other? We could form a business/career cooperative, of sorts. My very embriotic idea would be that we put together a business and skills directory which OCF members could consult when they are looking for someone to hire to do a job or to buy a service or product from. We could start at the Annual Convention. Everyone who has a service or skill or product to offer could put their business card or a short blurb on a "Work Board". Attendees could review to see if something or someone they need is available and, if feasible give that person a chance to bid or interview. With luck and funding, we could collect all the names and produce a list that we can publish on the website or in manual form. Each person who signs up could contribute a small fee to defray the cost. Is anyone interested in this? Write me, call me or fax me with your reactions. See you in Chicago. ■

Patricia Perkins-Doyle, J.D.
Executive Director

Mimicking OCD

Continued from page 6

disorder with obsessive-compulsive personality disorder (not OCD, but OCPD).

I have seen several persons treated effectively who have not responded to typical OCD treatment. Referral to a physician who is skilled in dealing with bipolar disorders that lie out of the diagnostic range set forth by DSM-IV diagnostic criteria is essential.

Counseling for these individuals also varies from the typical OCD treatment. Effective are: supportive therapy, cognitive-behavioral therapy, object relations and relational therapy, and life structuring and management training.

This treatment has proven beneficial for some OCD hoarders, leading one to wonder what the underlying disorder really is. Fortunately, for persons responding to this treatment, the gains are great.

In conclusion, there is a bipolar that can mimic OCD. It is possible that many persons taking a cocktail of medications for OCD and have made poor gains need to be reevaluated and bipolar disorder considered. It is difficult to diagnose this type of bipolar disorder and the evaluating therapist or physician needs a standard set of questions about the patient and the family psychiatric history. Time, observation, and noting reaction to medication is also an extremely valuable source for information to diagnose bipolar disorder. ■

(See Research Digest for related discussion)

OCD and Parenting

Continued from page 9

can influence the degree to which these symptoms affect the child's life.

Do create an atmosphere in which the child is comfortable talking about feelings, especially worries.

Do encourage your child to take reasonable risk.

Do demonstrate, by example, that anxiety is "no big deal."

Do work on co-parenting: don't allow the child to "divide and conquer."

Do adopt a healthy lifestyle, properly balancing social, work and family life.

Don't forget that anxiety is often contagious.

Don't "give in" to demands to provide unnecessary reassurance or to cooperate with rituals.

Do help your child to experience the many "unknowns" life has to offer.

Don't participate in your child's anxiety. ■

(See Research Digest for related discussion)

Revised Social Security Laws

Continued from page 5

bill provides a safety net for those who return to work and then have a relapse. Now, under the new provisions, if a recipient has a relapse and has to leave work again within 60 months/years, he/she can begin receiving social security disability benefits at the previous level within two weeks of the relapse.

The new sections of the act have changed the provisions on reinstatement of benefits to allow the recipient to receive benefits for up to six months while the Social Security Administration investigates the claim.

With this amendment, even if Social Security determines at the end of the investigation that the beneficiary is not totally disabled, the beneficiary will not have to pay back benefits paid during the investigation.

For more information, consult your local Social Security office or go on-line to the Social Security Administration's website at http://www.ssa.gov/odhome. ■

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