9th Annual Conference

OCD Newsletter

Philadelphia August 9-11, 2002

Volume 16 Number 2 | Published by The OC Foundation, Inc. | SPRING 2002

MANAGING SEXUAL SIDE EFFECTS

by Michael A. Jenike, M.D.
Chairman, OCF Scientific Advisory Board

Michael A. Jenike, M.D.

Although the positive effects of SSRIs, clomipramine, and monoamineoxidase inhibitors are now well documented, there is a cost in terms of side effects. It is clear that more than 35% of patients on these drugs experience difficulties with sexual functioning. These problems usually involve diminished libido (although the opposite occasionally occurs) and/or orgasm problems in both sexes. In males, inability to maintain an erection or even complete impotence may occur.

If the clinician does not specifically ask about sexual difficulties, it may appear that they are quite rare since patients are often embarrassed or more commonly, they do not think to blame medication for these problems and may attribute them to difficulties in their relationships. Sexual difficulties may be an unspoken cause of treatment noncompliance, and knowledge of the patient's sexual life may be a critical variable in drug compliance. To illustrate the magnitude of these problems, Montero (1987) studied clomipramine and found that 96% of patients who took the drug developed anorgasmia. However, when a sexual dysfunction questionnaire was given, only 36% of the 96% reported any type of sexual problem. When fluoxetine, sertraline, and paroxetine were first introduced, the reported incidence of sexual dysfunction was 2% to 9%; after careful questioning and better reporting of cases, the incidence is now 30% to 40%.

It is not completely clear what the mechanism of these sexual difficulties is, but most of the evidence for anorgasmia supports the hypothesis that increased serotonergic activity is inhibitory to ejaculation and orgasm. The various serotonin receptor subtypes may have different effects on sexual functioning; in particular, 5-HT2 receptors are probably inhibitory while other subtypes may be excitatory. This could account for the paradoxical effect of spontaneous orgasm in a small number of patients who have taken fluoxetine and clomipramine, even though both of these drugs cause extreme difficulty with ejaculation in the typical patient. These inconsistent effects may be explained by activation of certain receptors in some, but not all, patients (Seagraves et al, 1996).

The above effects can sometimes be reversed by medication like cyproheptadine, a drug with antiserotonergic action, as shown in a number of case reports (McCormick et al, 1990; Arnott & Nutt, 1994; Seagraves, 1991; Feder, 1991; Goldbloom & Kennedy, 1991) and in one

(continued on page 6)

A Letter from the President

Dear Friends,

I would like to bring you all up to date on the projects that so many of you have supported both with your time and your money.

RESEARCH

We are in the midst of selecting the 2002 OCF Research Award Winners. In response to our "Call for Projects," 21 proposals were submitted by the December 15, 2001 deadline. These initial "short form" proposals were evaluated by the Review Committee of our Scientific Advisory Board. This year's committee was chaired by Dr. Lorrin

Koran, Professor of Psychiatry and Director of the OCD Clinic at Stanford Medical Center. We want to thank him and his committee for taking on this commitment.

The Review Committee has selected 10 finalists who are preparing their complete proposals. The Committee will study these and then rank each project while considering several factors. This information will be presented in April to the Foundation's board of directors who will then choose the 2002 Research Award winners.

(continued on page 9)

From the Foundation

The push is on. While we actually started planning for the 9th Annual Conference when we got back from the last one, there's a point where it gets to be really serious. We hit it when Jeannette started logging in the presentation proposals in mid-January. We've got them all now. We have chosen more than 60 workshops, seminars, presentations and support groups out of 90 plus proposals we received. We've laid out a three-day program that will tire out the most determined participant, guaranteed.

We've spent the last two weeks reading last year's evaluations, checking out the latest areas of hot research, talking to people with OCD and their families, dropping in on the on-line support groups, and listening to mental health professionals to get a handle on what people want and need to know about OCD and the Spectrum Disorders. According to last year's evaluations, those who attended the Newcomers' and Children and Adolescents' Orientations liked them and got a lot out of them. So, they will be the first offerings early on Friday morning. Drs. Mansbridge and Claiborn will reprise their roles as guides to the nature, etiology and treatment of OCD. Glenn Wells, a long-time OCF member and conference participant, will give newcomers with OCD the inside scoop on where to go, what to see and who to meet to get the most out of the Conference. Chris Vertullo, secretary of the board of directors, is going to talk about the Foundation, what it does and how people can get involved.

At the same time, Drs. Lee Fitzgibbons and Karen Landsman, and therapist Kathy Parrish from the Anxiety & Agoraphobia Treatment Center, along with parent and board member, Carter Wadell, are going to welcome all the kids attending the Conference, introduce them to each other

(continued on page 10)

In This Issue

Please Designate the OCF as Your United Way/CFC Charity

BULLETIN BOARD

Brown University School of Medicine Seeks Participants for a Follow-Up Study of Obsessive Compulsive Disorder

Participants are needed for an NIMH-sponsored study that is designed to prospectively follow the long-term course of OCD in individuals with a primary diagnosis of OCD. This study is the first one of its kind, and will ultimately provide important new information about many aspects of treatment and the assessment of OCD. This is an interview study with annual follow-ups. Participants will be paid $25 for the first interview and $40 for annual follow-up interviews. Participation is strictly confidential.

Individuals (ages 6 and older) who have been diagnosed with OCD and have sought treatment for their OCD symptoms within the past 18 months are eligible to participate. Screening for this study takes approximately 10 minutes on the telephone.

Please contact:
Maria Mancebo, M.A.
Butler Hospital
345 Blackstone Boulevard
Providence, RI 02906
(401) 455-6216
mmancebo@butler.org

Participants Sought for a Yale/Columbia Study of OCD

The study seeks to learn more about the causes of various neuropsychiatric disorders including OCD. The study involves taking an MRI image of the brain (MRI is a safe, painless, radiation-free way to "take a picture" of the brain). It also involves responding to questions about medical and psychological histories and completing a neuropsychological assessment. By comparing the MRI data from individuals with disorders to that of healthy control individuals the study will help further our understanding of the neurological basis behind disorders such as OCD.

The study takes place at the Yale Child Study Center in New Haven, CT. Individuals with OCD, Tourettes, and/or ADHD as well as healthy controls between the ages of 6 and 65 are eligible for participation. Participants will be compensated $80 for their time.
For more information contact:
Patricia Onate at 212-543-6287 or email:
onatep@child.cpmc.columbia.edu

Cognitive Therapy for Obsessive-Compulsive Disorder

Description of the project: Massachusetts General Hospital/Harvard Medical School is seeking participants with Obsessive-Compulsive Disorder (OCD) to take part in a research study. The purpose of the research study is to examine the effectiveness of cognitive therapy for OCD. Participants will receive:

- a clinical evaluation, at no cost
- 22 sessions of cognitive therapy, at no cost

Who is eligible? If you are between 18 to 65 years of age and suffer from OCD, you might be eligible for this study. You must be able to attend weekly sessions in Boston. Benefits to the participants: You may not receive any benefits from participating. It is possible that your OCD symptoms may improve from the cognitive therapy examined in this study. So far, there is some evidence that cognitive therapy may help individuals suffering from OCD, however, clinical testing is still investigational at this time.

Contact information: This study is being conducted by Sabine Wilhelm, Ph.D., and Gail Steketee, Ph.D. If you are interested in further information about this research, please contact Ulrike at the OCD Clinic/Harvard Medical School at (617) 724-4354 or email at buhlmann@wjh.harvard.edu.

Help Yourself and the OCF at the Same Time

Order Dr. Jeffrey Schwartz' New CD " The Four Steps: New Developements On Progressive Mindfulness". This one CD contains seven lectures and an epilogue by Dr. Jeffery Schwartz, author of "Brain Lock". These lectures explain Dr. Schwartz' "Four Step" theory for self-managing OCD. Cost is $9.98 plus $4.50 for shipping and handling. To order, call Daisy Sanchez at the OCF 203.315.2190, ext. 13 or e-mail her at sanchez@ocfoundation.org. For a review of the CD by Dr. Michael A. Jenike, see the Winter 2002 issue of the OCD NEWSLETTER or the OCF website. Proceeds from the sale of the CD are being donated by Dr. Schwartz to support the Foundation's activities.

A copy of the official Florida registration and financial information of the Obsessive-Compulsive Foundation, a Connecticut non-profit corporation, may be obtained from the division of consumer services by calling toll-free within Florida 1-800-435-7352 or 1-850-488-2221 if calling from outside Florida.

Registration does not imply endorsement, approval or recommendation by the state of Florida. The OCF Florida registration number is SC-09749. The OCF does not have a professional solicitor. One hundred per cent of every contribution is received by the OCF. Donations will be used to underwrite the OCF's programs, activities and operations as well as for research.

Job Opportunity for Psychiatrist at Massachusetts General Hospital OCD Clinic

The OCD Clinic at Massachusetts General Hospital/Harvard Medical school invites applications for a Staff Psychiatrist position.

Applicants must have interest and experience in the treatment of OCD and related disorders. Responsibilities include patient care, running a clinical research trial and supervision of interns or residents.

We offer a supportive research environment and a chance to work with an excellent and experienced staff. Applications will be accepted until a suitable candidate is found.

If you are interested, please email Michael Jenike, MD (jenike@attbi.com).

OCD NEWSLETTER

The OCD Newsletter is published six times a year.

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

The Obsessive-Compulsive Foundation (OCF) is an international not-for-profit advocacy organization with more than 10,000 members worldwide. Its mission is to increase research, treatment and understanding of obsessive-compulsive disorder (OCD). In addition to its bi-monthly newsletter, OCF resources and activities include: an annual membership conference; popular website; training programs for mental health professionals; annual research awards; affiliates and support groups throughout the United States and Canada; referrals to registered treatment providers; and the distribution of books, videos, and other OCD-related materials through the OCF bookstore and other programs.

Anxiety Treatment Center of Northern California Has All the Challenges of Home

The following is an interview with Dr. Paul Munford about the intensive OCD treatment program available at the Anxiety Treatment Center of Northern California.

NEWSLETTER: Can you describe your Intensive Day Treatment Program for OCD at the Anxiety Treatment Center of Northern California for our readers?

DR. MUNFORD: Our Intensive Day Treatment Program is designed for people with OCD who need hands-on assistance from experts to do the therapeutic work. The program operates from 9 AM to 1 PM, Mondays through Fridays. The length of stay in the program depends on the needs of the particular client. However, most people spend an average of four to six weeks with us. Our treatment goal is to reduce symptoms to a level where the person can actively participate in school, work, volunteering, family and social activities without the limitations imposed by OCD. No more than six clients are enrolled at any one time.

The Intensive Program takes place in a comfortable, newly redecorated house in a quiet, residential neighborhood in Sacramento. The setting is representative of the typical home, thereby offering unique opportunities for exposure and response prevention exercises that are not available in hospital or clinic settings. Here people can engage in everyday activities that have been blocked by OCD. For example, people with contamination worries can learn to manage them by doing household chores that they have feared, such as, laundry, cooking, vacuuming, dusting and so forth. These and similar activities can also help patients who are overly responsible or perfectionistic learn to accept mistakes and set reasonable performance standards for themselves. Our home-like setting also makes it easier for clients to transfer skills learned in the program to their homes. And, as you would expect, the ambience is peaceful and hospitable.

NEWSLETTER: What treatment modalities do you employ in your intensive day treatment program? Do you employ both exposure and response prevention therapy and psychopharmacology? Any other treatment techniques?

DR. MUNFORD: We employ both exposure and response prevention therapy used either separately or in combination with psychopharmacology. We tailor our treatment plans to the particular needs of the individual. This could mean a combination of techniques including: exposure and response prevention, homework assignments, individual psychotherapy, OCD education, problem solving, social skills and assertiveness training, relaxation training, and stress management.

NEWSLETTER: What is the philosophy behind your Intensive Day Treatment Program?

DR. MUNFORD: OCD is a disorder of fear – fear that is inappropriate and excessive. When the fear is eliminated, so are the obsessions and compulsions. We believe that the best way to eliminate fear is for people to learn how to face it. So using proven methods, we teach clients how to face, embrace, and erase the fear. This is done with patience, compassion, and friendly persuasion. When they feel the fear fading, they become inspired to defeat it and take charge of their lives.

NEWSLETTER: Patients in your program play an integral part in each other's treatment. Can you explain how that works?

DR. MUNFORD: An important way in which we learn new behaviors is by imitating the behavior of others, particularly when it is successful. This occurs in our program when clients who have progressed in treatment help those who are just starting by modeling the correct practice of the therapeutic techniques. As a result, these beginners progress more rapidly and soon become models themselves for new clients.

NEWSLETTER: Who should consider enrolling in your Intensive Day Treatment Program?

DR. MUNFORD: We accept patients who need supervised guidance over their course of treatment. Perhaps they have tried outpatient therapy with no success, or they may live in communities where no effective therapy is available. We also accept people with OCD who have other conditions as well. For example, we have successfully treated OCD in combination with Asperger's Syndrome, Social Phobia, Eating Disorders, Trichotillomania and Depression. We also welcome people with obsessions only.

NEWSLETTER: Do you treat children and adolescents in your program or just adults?

DR. MUNFORD: We treat children and adolescents on an outpatient basis. However, we accept only those who are 18 years of age and older in our Intensive Day Treatment Program.

NEWSLETTER: Do you have a set duration for your Intensive Program or does the length vary with the individual case?

DR. MUNFORD: There is no set duration for our Intensive Program. The length varies with each individual case. However, most people spend four to six weeks with us. Some stay for shorter periods.

NEWSLETTER: How do you determine how long a person with OCD will stay in the program?

DR. MUNFORD: We determine how long a person stays in the program in collaboration with the person. His/her treatment progress is periodically assessed with the Yale-Brown Obsessive Compulsive Scale, the Brief Symptom Inventory, and the Target Complaint Scale. This information is used in making the determination along with observations of staff and, when appropriate, the clients' significant others.

NEWSLETTER: What's included in a typical day in your program?

DR. MUNFORD: A typical day begins with a group meeting to discuss the previous day's homework and set objectives for the day. After this, clients work individually with staff for approximately three hours doing supervised exposure and response prevention therapy. During this period, individual psychotherapy, and family consultation is also provided for individual issues. The day ends with another group meeting for sharing achievements and homework assignments.

NEWSLETTER: What happens on the first day of your program?

DR. MUNFORD: The first day of the program is spent familiarizing the client with the program, and getting to know the staff. We also begin our initial assessment by having the clients complete questionnaires that survey their OCD and provide information on their personal history and overall psychological health. We review the general operations of the program and provide them with information regarding their rights and privileges as clients as well as our responsibilities to them. We formulate a general picture of their OCD symptoms and collaboratively outline treatment goals. With this information, we define our first treatment objectives.

NEWSLETTER: Your program is a day program; do you have facilities for anyone who does not live within commuting distance?

DR. MUNFORD: We do not have facilities for those who do not live within commuting distance. However, affordable lodging is available nearby. We have a list of inns and hotels that we can provide to anyone who wishes it. In the near future, we hope to be able to provide separate residential housing, within walking distance, for clients.

NEWSLETTER: What is your background in treating OCD?

DR. MUNFORD: I am a licensed clinical psychologist and executive director of the Program. I started working with OCD in the early 1980s while an Adjunct Associate Professor of Psychiatry, UCLA School of Medicine. Subsequently I have treated several hundred patients with OCD and other anxiety disorders; trained and supervised psychology interns, psychiatric residents, and other mental health professionals; and conducted research. I also developed and directed the behavior therapy component of the OCD Partial Hospitalization Program at the Neuropsychiatric Institute, UCLA. After retiring from the university as an Adjunct Professor of Psychiatry, I relocated to the Sacramento area and continue specializing in cognitive behavior therapy of the anxiety disorders. I also continue teaching and training psychiatry residents and other mental health trainees at the University Of California, Davis School of Medicine, where I am Clinical Professor in the Department of Psychiatry.

NEWSLETTER: How large is your staff? What are their backgrounds?

(continued on page 11)

How do I know this is the one for me?

(This is the second installment of a two-part article. In the first installment, Dr. Phillipson discussed obsessional doubt and the gay spike. In this second part, he discusses the obsessional doubts that arise from trying to determine whether a "love relationship" is "right" enough to be continued.)

by Steven J. Phillipson Ph.D.,.Clinical Director, Center for Cognitive Behavioral Psychotherapy*

Another common OCD relationship obsession is the inability to clearly discern the emotional rationale for remaining in a relationship. OCD sufferers whose spike theme entails substantiating their relationship often rely on measurements of their emotional intensity as a justification for whether or not they should actually be in the relationship. People with this spike theme will also endlessly analyze what they or society believe to be the "correct" qualities which make up a meaningful relationship.

Reading One's Own Emotional Scale

When a person with this spike theme makes an effort to use emotional reactivity to justify his or her own level of commitment, the most common outcome is to feel either nothing or just anxiety. During intimate moments where the OCD sufferer finds that he or she happens to be experiencing fulfillment with his or her partner, a spike often accompanies this realization and the experience of stimulation evaporates. Attempting to critically analyze one's level of arousal has the predictable and paradoxical effect of negating the actual experience. Sexually speaking, erections are lost and lubrication evaporates when focus is placed on the need to maintain arousal to prove that one's physical signals clearly signify that one is with the "right" person. Ultimately, there is no proof or test as to one's justification for being in a relationship. The infinite variables used by people to justify remaining in a relationship are too complex to develop a model, which can be used to reliably guide ourselves or others. Consequently, we are left with the notion of the "unjustified choice" to either remain in or to terminate the relationship. This phrase implies that one chooses to be determined and committed to another person. One cannot conceptualize through endless ruminations the reasons for ending a relationship or justify remaining in one. Hence the phrase: "There are no answers, only choices!"

Finding My One and Only

All OCD sufferers possess a driving force to prove that their own particular risk is not justified. Most persons with OCD will readily admit that they are painfully aware that the nature of what they spike about is irrational. Among persons with relationship justification spikes, there tends to be much less clarity about the irrational nature of their particular concern. This is in large part due to western society's romantic notions about what being in a relationship entails. Our fairy tales and popular media present all-loving relationships as being endlessly earth-shaking experiences. There is very little mention that being with the same person over a long period of time tends to create a habituated effect, such that, we actually get our appetite back and do find that there may be at least one other person on this planet whom we also find attractive.

In general, people with relationship spikes seem substantially more perfectionistic in their actual life philosophy then the general OCD population at large. This perfectionistic tendency leads to the belief that the answers to some basic questions will ultimately prove whether one is with the correct person. Examples of questions include: "Do I love him?" "Is she right for me?" "Isn't it reasonable to assume that I could find someone just as good, but who doesn't leave the toilet seat up?"

The OCD sufferer is so desperate for a definitive answer that he cannot casually gaze at his partner to get an affirmation of his true feelings. In the overall attempt to find the rational for remaining in the relationship, the mind acts like a high powered microscope and general experiences of satisfaction are replaced by a focus on minute details. People with this spike theme will often focus intently on the most minute defects, such as, the partner's too thick eyebrows or the excessive dryness of her skin. Questions might even arise regarding one's own laugh intensity in attempting to ascertain whether a response to a joke was a sufficient reply to one's partner's humor. "Oh, my god! If I don't think he's funny enough what am I doing with him?" Feelings of satisfaction and happiness occur naturally in the course of the relationship as long as one does not actively seek them out in an effort to get a definite answer. As a result, a relationship spiker's emotional connectedness can only be experienced at his or her psychological periphery.

Absence makes the heart grow fonder

The aftermath of this desperate need to measure the emotional intensity of a person's commitment can greatly influence a person's choice to remain in the relationship. Relationships can be like a revolving door when persons end their commitments in an effort to turn off the endless cycle of mental anguish. A constant temptation for relationship spikers is to see what peace they would experience if they break up with their partner. Generally, people with this spike theme believe that their ruminations indicate that a fundamental defect exists with the relationship. On the contrary, the vast majority of these relationships function in an exceptionally healthy way. This tendency explains why many significant others remain devoted despite their partner's constant doubts. The choice to get married despite one's mental anguish is occasionally made to put an end to the uncertainty. The rational is: that since I have taken the plunge, the nagging question is brought to a close. Unfortunately, neither marriage nor separation really brings an end to the toil. This explains why a number of patients have initiated therapy up to five years after they have ended a relationship and are still trying to stop questioning themselves about whether they made the correct choice by ending the relationship.

The saying "absence makes the heart grow fonder" is apropos with this type of OCD obsession. Usually, when one follows through with the urge to break away, the realization of what has been lost comes back with a vengeance. People with this form of OCD, who have ended relationships, often ruminate incessantly after the fact about whether they made the correct choice or not. After the relationship has ended, the mind becomes very selectively focused on only the positive memories and tends to disqualify the negative times. The natural discord associated with getting "the answer" in regard to whether to be in the relationship is tremendous. When OCD is involved, the magnitude of this discord is amplified to the point of torment. Individuals, who in their reasonable mind, are aware that the relationship is truly over, can still spend hours pondering whether or not it might still be worthwhile making one more attempt to salvage it. When this element of obsession is pre-

(continued on page 5)

Or Is this Mr. Right or Mr. Right-Now?

sent, the natural healing effects of time tend to be eliminated.

There Must Be Fifty Reasons to Leave Your Lover

The most common justification for terminating a basically good relationship is the absence of the anticipated emotional longing and desire for the partner. In the absence of these feelings, people with this obsession interpret their experience (i.e. anxiety, depersonalization, derealization, etc.) as an uncomfortable emptiness. To the person experiencing this type of obsession it seems that the only way to end the obsessing is to end the relationship. A "relationship obsessor" will decide to terminate the relationship by concluding that since in the "right" relationship a lover feels love, the present relationship can't be right because he doesn't "feel" love. He just feels stymied by his continuous obsessing. These people often contemplate and occasionally dabble in affairs in an effort to establish whether they would feel differently if they were with someone else.

There are a number of other common rationales that "relationship obsessors" focus on which keep the endless desperate cycle spinning. The belief in a "singular soul mate" can promote an intense need to feel that the person they are with is compatible with them in every way. Minor differences, which in any other relationship would easily be absorbed into the natural diversity of relationships in general, become extreme points of contention. For example, "If I don't fully appreciate my partner's sense of humor, then wouldn't I be better off finding someone who is just like my partner, but whose sense of humor I could appreciate more?" Another common misconception is that, "If I find someone else attractive, it means that my partner and I were not 'meant to be' or I'm not sufficiently attracted to her." Being aware that one can still find others attractive at any point in a healthy relationship is an important basis from which to operate. Believing that one's soul mate should be perfectly compatible in every way, and/or uniquely and completely attractive results in endless doubts and insecurities about the person being your "true" soul mate.

One possible reason for the prevalence of this spike theme is the common notion in society that one should "feel" in love with her partner. Being guided by one's "true feelings" is a popular romantic notion which plays itself out in a variety of media venues. The author, M. Scott Peck, wrote in the book *The Road Less Traveled* that a committed love is one based on the conscious effort to prioritize one's partner and make CHOICES which demonstrate one's level of commitment. He emphasized that romantic love, in contrast, is an attachment based on the intensity of an overwhelming experience. Some people will end a long-term relationship because they no longer feel the original levels of emotional intensity. Often the statement "I love you, but I'm not IN LOVE with you," becomes a justification for ending the relationship.

Living In the Choice

The treatment strategies with this form of OCD share many similarities to the treatment previously outlined in the first installment of this article for the sexual orientation spike. A gradual acceptance of living with uncertainty and accepting the discomfort of not having a definitive answer are paramount features of these treatments. The essence of the therapeutic goal is expressed in the question: "Are you living in the choice or in the experience?" "Living in the experience" implies using one's feelings to gain insight into the justification of continuing. For persons with this type of OCD, "living in the experience" perpetuates the endless cycle of seeking emotional justification to derive a conclusion about the worthwhileness of continuing in the relationship. "Living in the choice" means accepting that, with this spike, I can ultimately make an unjustified choice about living with this person and accepting the uncertainty about the "absolute rightness" of the relationship.

I often ask my relationship-obsessive patients to ask themselves if they could continue in their present relationship based solely on making a choice to continue it even though they don't "feel" what they believe to be love. I strongly encourage my patients to seek their spike rather than to passively await its intrusion. A common therapeutic home-based challenge might entail carrying in one's pocket a stack of ten index cards. Each index card lists a separate rationale for ending one's relationship. While reviewing each card ten times a day, the patient rates the level of intensity that each spike presents. Then he marks down next to the first number another one that represents the level of resistance he is choosing to offer the spike. This second number is extremely important and generally represents the foundation of this entire therapy. Basically, the less resistance one has to any spike theme, the greater the chance of habituation (i.e., getting used to the spike and not being emotionally responsive to it). Through choosing to expose one's self daily to these ideas, habituation can set in and the unsettling reminders become neutralized. Being willing to let go of all the sound justifications, which society strongly promotes in regard to "going with your true feelings," is of paramount importance.

The following is the traditional behavioral treatment process for this type of obsession: First, a hierarchy is established related to a graduated list of threatening ideas associated with remaining with one's partner. This list might include items which represent the partner's flaws or potential shortcomings which might justify terminating the relationship. Perhaps carrying around a picture of one's partner which portrays the person in a unflattering light would help expose the OCD sufferer to the question of not feeling enough love to remain in the relationship. Making the choice to do such a counter-intuitive act also helps instill the principle of being proactive, rather then a victim of these thoughts.

For a "relationship obsessive" engaging in sexual relations often is a spike. So, I usually encourage them to focus entirely on providing one's partner with pleasure and not to attempt to ascertain whether their body is reacting in a reassuring way. With many secure relationships, a heirarcy can be established involving a progression of behaviorally intimate acts which purposely expose the OCD sufferer to increasing questions pertaining to one's expected level of arousal. This exercise needs lightness and humor. There should be a progression to more intense levels of sexual activity with the aim of the relationship obsessive being not to get aroused. The fact that he does, despite trying to dissuade himself by making disparaging comments about the situation and forcing himself to entertain unattractive mental images, will go a long way to silencing the constant questions about the validity of the relationship that are always aroused by engaging in sex.

What someone suffering from relationship obsessions and his partner have to remember is that these obsessions are treatable. But, it takes some creativity on the part of the therapist and the partners as well as a willingness to take some risks. Let me conclude by saying that these spike themes are easily mistaken for "real life" issues. They aren't; they are obsessions masquerading as real issues. But, don't despair. These obsessions can be successfully treated using the tools I've outlined above.

**Dr. Steven Phillipson can be reached at 212.686.6886.*

MANAGING SEXUAL SIDE EFFECTS

(continued from page 1)

double-blind study (Steele & Howell, 1986). However, cyproheptadine can reverse the antidepressant effects of SSRIs (Feder, 1991) and probably antiobsessional effects as well. In addition, it has significant sedative properties.

Recent reports (Norden, 1994; Seagraves et al, 1996) suggest that adding buspirone, a partial agonist of the 5-HT1A autoreceptor, may have a beneficial effect of decreasing or reversing sexual dysfunctions induced by SSRIs.

Yohimbine, an alpha-2 adrenergic antagonist, has also been reported to be helpful for anorgasmia precipitated by SSRIs. It is probably best not used in patients with comorbid panic disorder, excessive agitation, or hypertension (Seagraves, 1994; Seagraves et al, 1996).

Bupropion is thought to have a predominantly adrenergic mechanism of action, and it has been reported to be successful in reversing fluoxetine-induced anorgasmia. It has been found that bupropion increases the sexual fantasy life in a cohort of women with hypoactive sexual desire and that using the drug may also have a central effect that enhances libido as well as a peripheral effect that reverses SSRI-induced sexual dysfunction (Seagraves et al, 1996).

In various case reports, dextroamphetamine, methylphenidate (Bartlik et al, 1995), amantadine (Balogh et al, 1992; Balon, 1996; Masand et al, 1994-95), and even ginseng have all been reported as useful drugs for reversing anorgasmia (Seagraves et al, 1996).

Reynolds (1997) reported that nefazodone (Serzone), a drug with less than a 1% incidence of anorgasmia, partially reversed sertraline-induced anorgasmia in a 31-year-old man at a dose of 100 mg per day; lower doses were not helpful. At 150 mg taken 60 minutes before intercourse, he had a return of normal sexual functioning. At 6 months follow-up, the patient had no ill effects from the occasional addition of nefazodone to his continung sertraline therapy. Reynolds noted that nefazodone has a relatively short half-life of only 2 to 4 hours and reaches peak serum levels 1 hour after oral dosing.

A recent approach to the management of sexual difficulties involves the use of drug holidays where patients are allowed to omit medications on the weekends to allow sexual activity. This practice may work when drugs that have a short half-life, such as, sertraline, paroxetine, clomipramine, and fluvoxamine are used, but will not work with drugs that have a very long half-life, such as fluoxetine.

A number of patients with drug induced sexual dysfunction can be helped by a little known technique of injection of the prostaglandin alprostadil into the corpus cavernosum of the penis (Caverject-Upjohn). This can produce an erection in some men with erectile dysfunction. Most men claim that this injection with a small bore needle is almost painless. However, a recent report of using a pellet or micro-suppository formulation that is used intraurethrally (MUSE [Medicated Urethral System for Erection] – Vivus) suggests that this technique may work as well without the need for injection. This is marketed as a sterile foil pouch containing a pellet, 1.4 mm in diameter and 3 or 6 mm long within the stem of a hollow applicator, which is inserted 3 cm deep into the urethra. Pressing a button pushes the pellet into the urethra. In a double-blind controlled trial of 461 alprostadil-treated patients, 299 (65%) reported that they had achieved successful intercourse at least once, compared to 95 (19%) of 500 patients who inserted placebo pellets. Results were similar regardless of age or cause of impotence (Padma-Nathan et al, 1997). MUSE comes in four strengths that range in cost from $114 to $138 for 6 units (The Medical Letter, 1997). The physician must determine the minimal effective dosage and check for hypotension before prescribing the drug for home use as there is about a 3% incidence of hypotension when the agent is first used.

In terms of patient management, some guidelines can be crystallized from the available literature. First, it is crucial to elicit a reasonable sexual history and ask directly about difficulties with libido (sexual drive), orgasm, erection, and satisfaction with sexual activity. Be clear with patients up front that antiobsessional and antidepressant medications are often associated with sexual difficulties. When identified, sometimes sexual problems can be lessened with simple dose reduction. Occasionally, these side effects diminish over time, but by no means in the majority of patients. Since there are now a number of effective antiobsessional drugs, it may be worth trying a switch to another drug, but if patients have had a good response, they may be reluctant to do this. Patients may have sexual difficulties on one or two antiobsessional agents, and perform normally on others.

If for some reason a patient does not want to change medication, several possible antidotes exist. Yohimbine is useful for anorgasmia except in patients with panic disorder, excessive agitation, or hypertension and can be given at a dose of 10.8 mg (2 tablets) approximately an hour before intended intercourse. Others have recommended chronic use of yohimbine at 5.4 mg given three times a day (Seagraves et al, 1996). Cyproheptadine can also be used on an as needed basis, but it often puts patients to sleep. There is also the theoretical concern that it may reverse antiobsessional and antidepressant drug effects. Amantadine has been used on an as needed basis and may be worth a try. Bupropion, given at a dose of 75-100 mg daily, may correct SSRI-induced sexual dysfunction. If for some reason the patient cannot tolerate bupropion, trazodone, 50-100 mg given daily can be used, especially for patients who have difficulties in developing and maintaining an erection (Seagraves et al, 199).

Sometimes combinations of these agents are used. For example, one report (Seagraves et al, 1996) advocated using bupropion starting at 37.5 mg given on a regular basis (not as needed) and increasing the dose to 75 mg daily, sometimes in combination with yohimbine 5.4 mg given daily. They also give methylphenidate 10 mg daily on occasion with beneficial results. Others recommend pemoline instead of methylphenidate as an adjunct, because it often reduces orgasm problems and has a half-life of 10 to 12 hours.

Caverject and MUSE systems may be helpful for some patients. Drug holidays are being advocated more and more for the shorter acting agents.

There are recent reports that ginkgo biloba, a botanical derived from tree bark, may allow for better sexual functioning for people taking SSRI's and other antidepressants. One article (Cohen, 1997) stated that "in an open trial of various formulations, ginkgo was found to be effective in 84% of patients with sexual dysfunction induced by antidepressants."

It is now theoretically possible the new drug, Viagra, may also be useful.

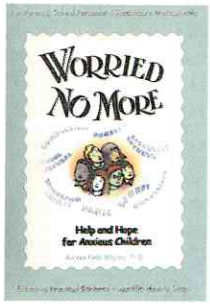
Above all, it is important to note the empirical nature of treating sexual difficulties and the need for flexibility. Multiple approaches, including biological and psychosocial, in an alliance with the physician, patient, and sexual partner are required. There is no way to determine in advance which patients will have sexual difficulties and then which approach will help them function. Several drugs and combinations may have to be tried. It is also important to monitor any concomitant medical problems or other medications that may have an effect on sexual functioning.

Book Reviews

Worried No More: Help and Hope for Anxious Children

by Aureen Pinto Wagner, Ph.D.

*Review by Lee Fitzgibbons, Ph.D.**



Worried No More: Help and Hope for Anxious Children by Aureen Pinto Wagner, Ph.D., is a welcome addition to the list of books produced for concerned parents and school personnel and for clinicians unfamiliar with Cognitive Behavior Therapy (CBT). It is a "must read" for these targeted audiences because the book is accurate, clear and easily understood. It provides the practical answers and strategies that parents/teachers/counselors are looking for.

Worried No More provides general information to bring the targeted audience up to speed on different anxiety problems. In it, Dr. Pinto Wagner discusses in general terms CBT and medications. These general chapters are easily understood, to-the-point and jargon free. She provides guidance on how to discriminate between normal anxiety from problem anxiety. She discusses warning symptoms and possible differences in presentation due to developmental age.

In my opinion, the most elegant chapter of the book is the one devoted to discussing the causes of anxiety disorders in children. Dr. Pinto Wagner explains the maintenance factors in incredibly clear and understandable language. She handles particularly well the delicate issue of parental reactions and responses that can accidentally and inadvertently strengthen an anxiety problem. Another section the author covers with expert ease is her explanation of habituation and how and why Exposure and Response Prevention (ERP) works. Because having this understanding is the first step towards success, these explanations alone make the book worth buying. Additionally, the book has many handy tables that simplify concepts for the reader. One that stands out is a nifty little table that highlights the differences between normal anxiety and problem anxiety.

Other highlights of the book are sections that focus specifically on what parents and school personnel can do to help alleviate a child's anxiety. The school chapter is particularly useful. In it, Dr. Pinto Wagner urges the school to respect and honor the knowledge and expertise of the parents. She also urges parents to understand the limited resources of schools and to assume that most school personnel want to be helpful. By focusing on the unique responsibilities of all the parties involved, the author shows how parents and teachers can build a team that truly works together for the best interest of the child they are trying to help. It has been my experience that school personnel and parents often initially look at each other as adversaries. Dr. Pinto Wagner provides useful guidance to help foster teamwork and specific actions the team can take to help the child.

There is also a chapter devoted to specific interventions that might be useful for a variety of anxiety disorders in children. The chapter presents many useful ideas. I hope that parents do not assume that armed with this book they can replace a clinician. Possibly to guard against this assumption, Dr. Wagner provides a list of questions to help parents find a good clinician.

I was very impressed with the "Worry Hill Memory Card" that Dr. Pinto Wagner devised and included in the book. Young children will be able to use this mnemonic device to keep in mind that, although the early part of an exposure exercise is hard work and involves feeling fear, when they get used to doing it, it will be as easy as coasting down a hill on a bike. This "Card" is a gem and the metaphor is a useful analogy for any parent or therapist.

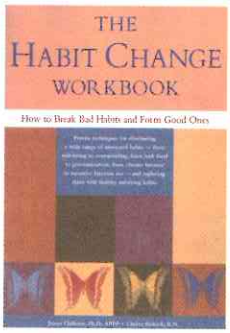
Overall, I give this book a hearty thumbs up!!

** Dr. Fitzgibbons treats children and adolescents with anxiety disorders at the Agoraphobia & Anxiety Treatment Center in Bala Cynwynd, PA.*

The Habit Change Workbook

by James Claiborn, Ph.D., and Cherry Pedrick, R.N.

Review by John Angelo*



James Claiborn, Ph.D. and co-author of *The Habit Change Workbook*, has an image of polar bears on his screen saver. The bears serve as a reminder to this cognitive behavioral therapist that changing thought patterns takes more than a flash of will power. The test at hand is NOT to think about polar bears once instructed to forget about them. No bear or human has yet passed the test.

"Let's face it," the authors write, "we could have written a book containing just one sentence: 'Don't do that!' But that wouldn't have been helpful."

Instead, *The Habit Change Workbook* offers a step-by-step approach to habit change for anyone willing to take the journey. Will power is but the first step in an honest self-evaluation of how a habit impacts your life, how you can take concrete steps to change, and how to replace a negative behavior with a positive one. The seven specific habits addressed in the book fall under the categories of nervous habits, sleeping problems, habits that affect health, habits that affect relationships, excessive leisure activities, excessive shopping and spending, and problem gambling.

The nuts and bolts of the book require keeping track of the thoughts and triggers that precede the negative habit and the consequences of the negative behavior. This is not easy work but the authors state early on: "We are responsible for our behaviors."

The key is to look for gradual improvement. The way to achieve the long-term goal of eradicating a negative behavior is to set specific short-term goals and take on greater challenges over time.

The authors, Claiborn who is a therapist in Manchester, New Hampshire, and Pedrick who is a nurse and writer from Nevada, connected over a free 10 page self-help guide Claiborn wrote on skin picking. Pedrick came across the guide on the Internet and suggested collaboration on the book that became *The Habit Change Workbook*.

The significance of this workbook for individuals with OCD is that the authors detail the differences between habits and OCD. Habits relieve generalized anxiety while OCD is tied to a specific anxiety. Habits such as excessive spending or gambling give pleasure, at least at first. OCD acts to keep dread away and offers no pleasure.

Then again, what Claiborn says about OCD might also be said about habits: "My experience is that most of the people who have this disorder (OCD) think that they're the only ones who have it."

The book is a valuable tool on the journey toward happiness.

** John Angelo has written for publications as varied as "Publishers Weekly" and "The Humanist." He has lived with OCD for many years.*

Both books are available through the OCF Bookstore.

Research is the Key. Please Support the Research Fund.

Research Digest

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.

Few individuals are free of all concern about their appearance, and those with total disregard are probably estranged from society in many other ways as well. At the opposite extreme are those obsessed with their appearance and intent on changing it for the better at all costs. Most of these individuals have features and body shapes well within the normal range - though not as they perceive themselves. Most preoccupations involve face and hair, but any body part can be their source of misperceived ugliness. Usually hours are spent inspecting the perceived defect although some avoid looking in mirrors to minimize distress. Their frequent pursuit of an altered appearance is fraught as almost all cosmetic attempts, including surgery, fail to satisfy them. These unhappy people suffer body dysmorphic disorder (BDD), which causes substantial distress and dysfunction in important life roles. BDD can be treated effectively with potent serotonin reuptake inhibitor medications and cognitive-behavior therapy, alone and in combination. The articles reviewed in this Research Digest address various aspects of BDD.

'I'm as ugly as the elephant man.' How to recognize and treat body dysmorphic disorder
Current Psychiatry, 1:58-65, 2002, K.A. Phillips

Dr. Phillips, a leading expert on body dysmorphic disorder (BDD), author of "The Broken Mirror: Understanding and Treating Body Dysmorphic Disorder." and coauthor of "The Adonis Complex: The Secret Crisis of Male Body Obsession," reviewed the diagnosis and treatment of BDD. Body dysmorphic disorder is a preoccupation with an imagined defect in appearance or excessive concern with a slight physical flaw. Individuals with this disorder will think about the perceived defect, on average, for 3 to 8 hours a day. It is a disorder causing notable distress and impaired functioning, and can lead to suicide. Frequently BDD goes undiagnosed, in part because many patients are too embarrassed to discuss their symptoms with their physicians unless specifically asked, but often because BDD is confused with other disorders. Selective serotonin reuptake inhibitors (SSRIs) are the first-line medications recommended and higher doses than needed for depression may be required. Cognitive-behavioral therapy (CBT) is also effective and the combination of CBT and potent SSRIs may be most effective.

Effectiveness of pharmacotherapy for body dysmorphic disorder: a chart-review study
Journal of Clinical Psychiatry, 62:721-727, 2001, K.A. Phillips, R.S. Albertini, J.M. Siniscalchi et al.

Body dysmorphic disorder (BDD), an obsession with an imagined or slight defect in appearance, is a disorder related to OCD. Although current first-line medication treatment is serotonin reuptake inhibitors (SRIs), there is little research on SRIs for BDD. Reviewing medication treatment response of 90 patients in their clinical practices, authors assessed medication response, including augmentation strategies, and relapse rate with medication discontinuation. All 90 patients had received an SRI and 63.2% had a reduction in BDD symptoms. Consistent with previous research, subjects delusional about their body shape were as likely as nondelusional subjects to respond to SRIs. Similar response rates were found for fluoxetine (Prozac), paroxetine (Paxil), fluvoxamine (Luvox), sertraline (Zoloft) and clomipramine (Anafranil). Of interest, a substantial percentage of individuals who failed an initial SRI responded to a subsequent SRI. Augmentation of an SSRI with clomipramine or any SRI with buspirone (BuSpar), lithium, methylphenidate (Ritalin), or antipsychotics was beneficial for some individuals. Augmentation was found to be more successful when patients had partially responded to an SRI. Discontinuation of an effective SRI resulted in relapse of BDD in 83.8% of cases. This finding suggests that long-term SRI treatment may be necessary.

Psychopathology and body image in cosmetic surgery patients
Aesthetic Plastic Surgery, 25:474-478, 2001, S. Vargel and A. Ulusahin

This study investigated the presence of psychiatric symptoms and body image in 20 cosmetic surgery patients. Four of the 20 (20%) were diagnosed with body dysmorphic disorder (BDD). The authors briefly describe the cases: a 34-year-old woman obsessed over her eye wrinkles wore large sunglasses to hide them; a 26-year-old man obsessed over the roughness of his skin avoided all types of social contact; a 19-year-old man obsessed over the slant of his earlobes believed that girls would not find him attractive because of this defect (two years earlier he had an earlobe operation and was unhappy with the results); a 25-year-old woman obsessed over the ugliness of her face attributed negative attitudes towards her as due to her ugliness. Individuals with BDD seeking cosmetic surgery have been reported to be reluctant to undergo psychological assessment and these four were reluctant to take the psychological tests. Identification of BDD is important because patients with BDD are usually dissatisfied with the results of cosmetic surgery.

Mirror, mirror on the wall, who's the largest of them all? The features and phenomenology of muscle dysmorphia
Harvard Review of Psychiatry, 9:254-259, 2001, R. Olivardia

Muscle dysmorphia, a preoccupation with the idea that one's body is not sufficiently lean and muscular, is a form of body dysmorphic disorder. Dr. Olivardia, coauthor of "The Adonis Complex: The Secret Crisis of Male Body Obsession," describes the disorder and gives information on prevalence, diagnosis and treatment. Although muscle dysmorphia affects a large number of men, it is found in only a small percentage of weightlifters, approximately 5%. While ordinary weightlifters spend about 40 minutes a day thinking about being too small or getting bigger, men with muscle dysmorphia report spending over 5 hours per day thinking such thoughts. Behaviors associated with muscle dysmorphia include long hours of lifting weights, excessive attention to diet, mirror-checking and use of steroids. Although not studied, the treatment recommended is a combination of selective serotonin reuptake inhibitors and cognitive-behavioral therapy.

Mirror, mirror on the wall, who is the ugliest of them all? The psychopathology of mirror gazing in body dysmorphic disorder
Behaviour Research and Therapy, 39:1381-1393, 2001, D. Veale and S. Riley

Mirror gazing, spending extended amounts of time in front of mirrors, occurs in about 80% of patients with body dysmorphic disorder (BDD). The other patients with BDD tend to avoid mirrors because of the distress they feel in seeing the imagined defect. These researchers studied beliefs behind mirror gazing and behaviors accompanying mirror gazing. BDD patients would check mirrors for a variety of reasons - in hopes they would look different, to know how they looked, a belief that they would feel worse if they didn't look into a mirror and a desire to camouflage the defect they obsessed over. Instead of having the mirror gazing briefly reduce anxiety, as does checking for patients with OCD, the BDD patients felt worse after mirror gazing. Patients reported seeing distorted images that reflected how they felt internally. As a result of this study, Drs. Veale and Riley have adapted their behavior therapy strategies to help BDD patients stop mirror gazing. Instead of working on avoidance of mirrors, they suggest teaching patients to use mirrors in a healthy way with time limits. Patients are encouraged to use larger mirrors and mirrors at a slight distance, focusing attention on the whole of their face or body rather than on a specific area.

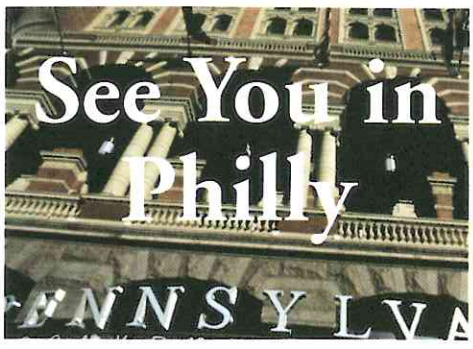
Research Digest

Additionally they work to reduce the amount of make-up (camouflaging) as this tends to reduce the amount of time spent in front of a mirror.

Surgical and nonpsychiatric medical treatment of patients with body dysmorphic disorder

Psychosomatics, 42:504-510, 2001, K.A. Phillips, J. Grant, J. Siniscalchi et al.

Individuals with body dysmorphic disorder (BDD) often seek cosmetic surgery, dermatologic treatment and other nonpsychiatric medical treatment for their perceived defects and they are generally not satisfied with the outcomes from these treatments. Assessing the frequency and kinds of nonpsychiatric treatments sought and received by 289 individuals with BDD, researchers found that nonpsychiatric treatments were sought by 76.4% and received by 66.0%. Thus, a majority of patients with BDD received nonpsychiatric treatment. Dermatologic treatment was the most often received treatment (45.2% of adults), followed by cosmetic surgery (23.2% of adults). Physicians refused to provide more than one-quarter of all requested treatments, although some patients continued to seek treatment from other dermatologists and surgeons. Men were as likely as women to receive cosmetic surgery, which contrasts BDD with the general population where men are less likely than women to have cosmetic surgery. There was no significant association between the number of nonpsychiatric treatments sought or received and the severity of the BDD. These treatments rarely improved BDD symptoms, only 7.3% of all treatments led to a decrease in concern with the treated body part and overall improvement in BDD. In the majority of cases where these treatments resulted in a decreased concern with the treated body part, the patients tended to worry more about another perceived defect, became more concerned about more minor imperfections in the treated area, or worried that an improved body part would become ugly again. Researchers concluded that nonpsychiatric medical treatments were frequently sought and usually did not improve BDD symptoms.



A Letter from the President

(continued from page 1)

This process is always very exciting. The proposals we received deal with various aspects of OCD, including research into the relationship of OCD and comorbid disorders, the effectiveness of home-based behavioral treatment, the variations in treatment responses for different OC symptom types, the effectiveness of treatments on metabolic and neurocognitive functions and serotonin uptake inhibitor response.

We will fund as many of these excellent projects as we can. Fortunately, we were able to raise an additional $108,186.37 during our fundraising campaign from December 1, 2001 through February 28, 2002 to add to the OCFoundation Research Fund. Thank you to everyone who contributed.

We would like to be able to offer established investigators more funds for more in depth research and would also like to encourage young investigators to direct their research to OCD. There is still so much more research that needs to be done: We need to discover what strep has to do with the onset of OCD in children. We need to determine the role of neurosurgery. We need to learn why available medications only work for 60% of the patient population and help some more than others. We have to discover why OCD patients have abnormal white brain matter. We need to find out why boys experience an earlier onset of OCD than girls. We need to find out if OCD is genetic. And, we must find a cure for everyone. There is much to do. However, we can be proud that the Foundation – with your help – is making this important OCD research a reality.

THE OCD GENETICS CONSORTIUM

Thirty-one researchers from the United States, Canada, Mexico, Israel, France, Germany, Brazil, Italy and the Netherlands have accepted the Foundation's invitation to attend our organizational meeting. We've scheduled this meeting for August 11, 2002, the last day of the 9th Annual OCF Conference to be held in Philadelphia. At this meeting, the group which is led by Drs. David Pauls and Michael A. Jenike, will discuss how they can work together to determine if OCD has a genetic basis and, if so, how this knowledge can lead to the prevention and/or cure of OCD.

To date, we have raised a little over $16,000 to fund the work of the Consortium. This has been accomplished with the help of Nancy and Robert Guenther who held a successful fundraiser last October and through gifts, large and small from Foundation members. Our goal is $25,000 by August 2002. Please help us to reach this goal with either a personal donation or by hosting a fundraiser in your area. Contact our executive director, Patricia Perkins-Doyle at the Foundation for assistance if you are interested in holding a fundraiser.

EDUCATION TASK FORCE

The goal of this group is to develop information – print and video – that can be utilized to "educate the educators" of our children with OCD. The materials will include a training program for parents and others so that they can make presentations to appropriate school personnel. The Task Force is working on assembling a program that can be used to educate classroom teachers, school psychologists and special education teachers about how to work with children who have OCD. Many of you have contacted us and volunteered to be presenters once the program is completed. We will be calling on you to bring this program into your local schools.

I know that as we work together, we can move from development to the finished projects that provide hope and support for people with OCD.

Best regards,
Janet Emmerman
President, OCFoundation Board of Directors

RESIDENCE FOR PEOPLE WITH OCD: IT'S A POSSIBILITY

If you or a loved one have not been able to live on your own because of OCD, there's now hope. George Van, a member of the OCF and a concerned parent, is organizing a Housing Committee for parents, siblings and/or friends of adults with OCD who cannot live on their own without skilled assistance. "The goal of this group is to design and set up an apartment complex or group home where individuals who are severely disabled by OCD can live independently but have trained staff available 24 hours a day to help them with their problem areas and give them support," says Dr. Michael Jenike, director of the OCD Institute, who will be serving as medical advisor to this committee.

There will be a meeting of anyone interested in creating this type of housing option for individuals with severe OCD at the OC Foundation Annual Conference in Philadelphia, August 9-11, 2002. Currently, there are no group homes or apartments with assistance where people with moderate to severe OCD can live and get the expert support they need to manage their illness and their lives. This could be a solution to "living at home with parents" and/or nursing home confinement. If being able to live independently is your hope or your hope for a loved one with OCD, contact George Van at gpvanpira@usa.net and plan to attend the Housing Committee meeting at the Annual OCF Conference.

From the Foundation

(continued from page 1)

and give them a mini course on OCD and how to beat it.

Philadelphia is the hometown of cognitive behavior therapy. It's where Dr. Edna Foa practices and researches and where she trained many of the best and most active behaviorists working in anxiety disorders today. We're very lucky this year because Dr. Foa and Dr. Martin Franklin, her colleague from the Center for the Treatment and Study of Anxiety at the University of Pennsylvania, are going to be putting on two three-hour seminars for mental health professionals on Friday. Dr. Foa will be discussing and demonstrating "CBT for Adults with OCD' and Dr. Franklin will be covering CBT for Children with OCD.

Following last year's pattern, we've tried to set up tracks. There will be presentations that are geared primarily for individuals with OCD and their families. There will be seminars and workshops for parents of kids with OCD; and workshops, presentations and support groups for kids and teenagers with OCD. There will be seminars and presentation geared toward mental health professionals. We are approved to give CEU's to LCSWs, Marriage and Family Therapists, and Mental Health Counselors. Applications have been made to National Board for Certified Counselors, National Association of Social Workers, and the American Psychological Association.

There will be a research update by Drs. Wayne Goodman and Steven Rasmussen on surgical options and deep brain stimulation. The kids will be able to spend time in their own hospitality room on Friday and Saturday, working on art projects, writing articles for the second issue of their own newsletter, getting to know each other and having fun. They will also have special workshops and seminars, including "Story Writing to Beat the Brain Bug," "Dissin' OCD: CBT for kids and Teens," "Take That!: Strategies for Young People to Fight Their OCD," and "Adolescence Sucks.....and Then There's OCD."

Running contemporaneously with the children's groups will be workshops and presentations for parents by Drs. Aureen Pinto Wagner, Tamar Chansky, and Lee Fitzgibbons among others. There will also be seminar, panels and support groups by parents – Wendy Birkhan and, Kathy Hammes and the members of the OCDandParenting online support group.

There are going to be support groups of every type on Friday night. GOAL groups for kids and adults, an OCA group, a parents support group and a "Transitions Panel" for young adults. Capping off Friday night will be the "Virtual Camping Trip" through the streets of downtown Philly led by Jon Grayson and the Philadelphia GOAL Group/OCF Affiliate.

The Keynote Speech, "A Step Toward More Effective Pharmacotherapies" will be given by Dr. Pierre Blier of the University of Florida School of Medicine. In his talk, Dr. Blier will discuss what he and other researchers have learned about developing more effective medications to treat neurobiological disorders by studying the brain's chemistry. This talk will be accompanied by an animated short film produced by Dr. Blier and Disney Studios.

Dr. Jeffrey Schwartz will lecture on "Progressive Mindfulness" and his Four Step treatment program. Dr. Michael Jenike will take questions and respond with funny but insightful answers about medications used to treat OCD. Dr. Brian Martis is going to talk about neuroimaging research.

There will be two three-part seminars: one on Body Dismorphic Disorder and one on Pure Obsessions. They're both in that mythical state of "becoming" now, but it looks like both of them will pretty much follow the same format. There will be an introductory panel featuring experts discussing the problem and its treatment, followed by a segment featuring individuals who have overcome obsessional thinking or body dismorphic disorder and a concluding section for mental health providers on the most effective way to treat these distinctive manifestations of OCD.

While we are focusing mainly on OCD and its treatment, there will also be sessions on the spectrum disorders in general, and, individually, including presentations on trichotillomania, hoarding, panic disorder, self-mutation, hypochondriasis and in response to an oft repeated demand in last year's evaluations, a two-part presentation on Generalized Anxiety Disorder.

The first meeting of the OCD Genetics Consortium is scheduled for Sunday afternoon, August 11. Taking advantage of this, we've asked Drs. David Pauls and Gerald Nestadt to talk about what they have learned from their research.

OCD can corrode families and relationships. To help individuals with OCD and their families and loved one deal with the stress OCD can place on relationships, we've scheduled the following sessions: "Romantic Relationship Among Patients with OCD," "OCD and Parenting" "You, Me and OCD," and "Stop Living Under the Influence of OCD.

We've also lined up presentations on individual OCD symptoms, including "car killers," superstition, scrupulosity, and violent, blasphemous and sexual obsessions. And there will be workshops on applying CBT to conquering OCD, ranging from an exploration of CBT by phone to instructions on how to be your own CBT therapist.

There will be another Film Festival (Saturday night) featuring films by and about people with OCD. Patrick Johnson is sponsoring the OCD Art Contest and Exhibt again this year *(see below for more information)*. There will be two raffles this year (one for adults and one for kids) because last year's was so successful. The winners will be drawn at the Reception on Saturday night. On Sunday morning, we're reprising the Town Meeting which, according to the evaluations, was very popular last year. This year's Town Meeting topic is "Recovery." Dr. Jenike will be the master of ceremony and Gayle Frankel and Anna Mae Yurkanin, co-presidents of the Philadelphia affiliate, will be moderators of a panel whose members will talk about their journeys to recovery. After hearing from the panel, members of the audience will be invited to speak about their experiences or ask questions of any of the presenters.

We've got all these sessions and more blocked out on wall-length rolls of paper. We're now trying to transfer them to the typed page and then reduce them to a disk and e-mail it all to the printer so that we can have the Registration Brochure ready in late April. We're also lining up a conference airline and working with the people at the Wyndham Hotel in Philly to make sure that we have enough space for all our activities and enough rooms to house everyone who wants to attend the Conference. We're picking out raffle prizes and the menu for the Reception. We are soliciting corporate sponsors and advertisers. We looking for an art therapist for the Kids' Hospitality Room recruiting, room monitors to introduce the presenters and "Ask Me" people to answer questions and give directions.

It will be a little frantic around here from now until the Conference. Actually, sometimes it will be more than a little frantic, but it's also very exciting. We're looking forward to you joining us in Philly so we can all enjoy the Conference together.

Ciao!

Patricia Perkins-Doyle

Patricia Perkins-Doyle
Executive Director

ART CONTEST

The Obsessive Compulsive Foundation invites Artists interested in or affected by mental illness* to Enter and Exhibit their work in The 2002 OCF ART CONTEST and EXHIBIT at the 9th Annual OCF Conference August 9-11, 2002
Wyndham Franklin Plaza Hotel
Philadelphia, PA

FIRST PRIZE: $1,000.00
SECOND PRIZE: $100.00
THIRD PRIZE: $50.00

For more information and an entry form, contact OCF Deputy Director Jeannette Cole at cole@ocfoundation.org or 203.315.2190, ext. 18.
Application fee is $10.00 per entry

* Subject matter does not have to be related to mental illness.

Anxiety Treatment Center of Northern California Has All the Challenges of Home

(continued from page 3)

DR. MUNFORD: Our staff consists of four members. In addition to me, there are Dr. Robin D. Zasio, M.S.W., Psy.D, Christopher Morache, M.D., and Susan Haverty, B.A.

Dr. Zasio is a licensed clinical psychologist and Licensed Clinical Social Worker. She has 15 years experience working in outpatient, partial hospitalization, and inpatient programs. In addition, she has managed two of the most successful residential recovery homes in the Sacramento area. I trained Dr. Zasio, with whom I've been working for over three years, in the treatment of OCD. Her expertise, energy, and enthusiasm motivate clients to overcome their symptoms.

Dr. Morache is our medical director. As a licensed physician, trained in both Psychiatry and Family Practice, he treats patients with psychiatric illnesses and with physical illnesses. His special areas of interest are OCD, Personality Disorders, Post Traumatic Stress Disorder, and chronic pain.

Ms. Susan Haverty is our administrative assistant. She is presently completing her thesis for a master's degree in psychology from California State University in Sacramento. She also works with the Solano County Department of Mental Health as a crisis worker where she evaluates patients for community and inpatient treatment.

NEWSLETTER: What is your patient-to-staff ratio?

DR. MUNFORD: Depending on the number of clients in the program at any one time, the patient-to-staff ratio varies from one patient per staff to two patients per staff. We limit the total number of patients to six so we can provide this low patient to staff ratio.

NEWSLETTER: OCD is a chronic illness, what kind of relapse prevention program is there at the Center?

DR. MUNFORD: Prior to completing the program, clients are provided with specific recommendations for preventing relapse. In addition, ongoing outpatient appointments are scheduled for those living within commuting distance of our office. Telephone follow-up consultations are scheduled for others who do not live locally; or they are referred to qualified mental health professionals in their communities. If these therapists have no or limited experience with cognitive behavior therapy for OCD, we are willing to provide telephone consultation to them.

NEWSLETTER: Do you involve family members and significant others in your treatment program?

DR. MUNFORD: Family members and significant others are involved in the treatment program to an extent that does not violate the client' s confidentiality. With the client's consent, we find it helpful to teach family members and others how to help with homework assignments. We also find it quite important to work with clients and their helpers to eliminate any support for avoidance, compulsions and, especially, needless reassurances. We also provide counseling to resolve interpersonal problems that impede recovery from OCD.

NEWSLETTER: What kind of follow-up treatment do you provide for your patients?

DR. MUNFORD: We provide follow-up treatment on an outpatient basis for clients who can come to our office and make referrals to other professionals for those who live in other locales. We also provide treatment summaries and telephone follow-up to referring professionals and agencies and treatment consultation when requested.

NEWSLETTER: The Center has three distinct treatment programs. Can you describe and differentiate them for our readers? How does a prospective patient determine which of these programs is most suitable?

Dr. Paul Munford

Dr. Robin Zasio

Dr. Christopher Morache

Susan Haverty

DR. MUNFORD: We offer three treatment programs: group treatment for those with mild to moderate OCD who can benefit from the least expensive treatment program; individual treatment for mild to severe OCD requiring once or twice a week 45-50 minute sessions; and intensive day treatment for moderate to extreme OCD for those who have not responded or have no local access to outpatient therapy.

NEWSLETTER: Do you admit people on an emergency basis to your Intensive Day Treatment Program?

DR. MUNFORD: We can admit people to our Intensive Day Treatment Program on an emergency basis provided they have medical clearance from a physician verifying that they do not need 24-hour medically supervised care.

NEWSLETTER: How do you determine who should be in an inpatient program and who should be in the Intensive Day Treatment Program?

DR. MUNFORD: Inpatient hospitalization should be considered for clients who need 24-hour supervision for exposure and response prevention therapy to be successful or who need medical supervision for co-occurring complex psychiatric, substance abuse, and/or physical problems. Our Intensive Day Treatment Program is for clients without these complications and who are willing and able to participate fully in the program.

NEWSLETTER: Does your program involve any in-home visits if an individual has OCD rituals that are concentrated in his/her home?

DR. MUNFORD: We offer in-home visits to eliminate OCD rituals that are localized to the home when this is the only way to treat the disorder.

NEWSLETTER: Can individuals with co-morbid conditions or substance abuse problems be admitted to any of your OCD programs?

DR. MUNFORD: As mentioned above, we frequently treat individuals with co-morbid psychological conditions, such as Social Phobia, Asperger's Syndrome, Eating Disorders, Habit Disorders (Trichotillomania), and Personality Disorders. We require substance abuse problems to be treated before clients enter our program.

NEWSLETTER: Are your programs covered by private insurance? Medicare? Medicaid?

DR. MUNFORD: Some of our programs are covered by private insurance. Coverage is determined on a case-by-case basis. We're not covered by Medicaid but we do accept Medicare clients for outpatient treatment.

NEWSLETTER: Do you treat the Spectrum Disorders in your program?

DR. MUNFORD: We treat Hypochondriasis and as previously mentioned, Eating Disorders and Habit Disorders.

NEWSLETTER: Are there any research trials at the Center?

DR. MUNFORD: No pharmacological research trials are being conducted at the Center. However, we are conducting outcome research on the efficacy of our treatment programs.

NEWSLETTER: Does the Center have any programs to provide assistance to individuals who don't have the necessary financial resources to afford treatment at the Center?

DR. MUNFORD: I am sorry to say that we do not.

NEWSLETTER: If someone is interested in enrolling in a program at the Center or wants more information, whom should he call or contact? What's the phone number?

DR. MUNFORD: To enroll in the program or obtain more information about it, ***Call Dr. Paul R. Munford, at (916) 922-7876 or e-mail: ocd@northvalley.com.***

To Continue, we need YOU

Name _____

Address _____ City _____

State _____ Zip _____ Telephone (_____) _____ Email Address _____

❑ Please renew my membership in the OC Foundation

❑ I wish to become a member of the OC Foundation

❑ $45 Regular Member (Canadian US $50, Overseas US $55)

❑ $65 Family Membership (Canadian US $70, Overseas US $75)

❑ $85 Professional Member (Canadian US $90, Overseas US $95)

❑ **Additional Donation**

❑ Matching gifts from your employer (please enclose forms)

Credit Card Payment Authorization: For your convenience, we accept Visa, MasterCard, American Express and Discover.

Please check method of payment : ❑ VISA ❑ MASTERCARD ❑ AMERICAN EXPRESS ❑ DISCOVER

Credit Card #_____Expiration date _____

Amount $_____ Signature _____ Date _____

Please enclose payment. Checks, made on U.S. banks, should be made payable to OCF, Inc. and mailed to:

OCF, P.O. Box 9573, New Haven, CT 06535

Telephone: (203) 315-2190 Fax: (203) 315-2196 E-mail: info@ocfoundation.org

ADDITIONAL DONATIONS TO SUPPORT OCF'S WORK ARE GRATEFULLY ACCEPTED.

You may photocopy form to keep your Newsletter intact.

www.ocfoundation.org

OCF
P.O. Box 9573
New Haven, CT 06535

Address Service Requested

Time-Sensitive Material — DO NOT DELAY!

Non-Profit
U.S. Postage
PAID
North Branford, CT
Permit No. 58