

Treatment of Obsessive Compulsive Hoarding in an Intensive Treatment Setting

by *Karron Maidment RN, M.A.*

This is the second of a series of articles on Obsessive Compulsive hoarding. In this article, I'm going to discuss how our group at the OCD Intensive Treatment Program at UCLA treats hoarding. The intensive treatment program for hoarding at UCLA is a six-week program that runs five days a week, Monday through Friday, from 9-1 p.m. Much of the treatment for Obsessive Compulsive hoarding that is done in this program is based on the work of Drs. Randy Frost and Gail Steketee (see "Compulsive Hoarding: New Developments in Treatment and Research," Winter 2003 OCD NEWSLETTER).

At the UCLA program, treatment begins with a thorough assessment of:

- * Amount and type of clutter
- * Beliefs about the loss of clutter

- * Level of functioning - 84% of the people with the hoarding problem in our program were unable to work as a direct result of their hoarding.
- * Level of support from friends and family
- * Medication compliance
- * Comorbidity
- * Motivation for treatment
- * Level of insight and understanding of the disorder

Education is a very important component of the UCLA treatment program. Patients learn to conceptualize their hoarding in terms of problems with:

- * Information processing
- * Beliefs about and attachments to possessions

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For Me, Sin Lurked Everywhere

By *Deborah Deasy*

I wished I had never been born. When I was ten years old I began to worry a great deal about my sinfulness. I came to believe that sin lurked everywhere, and it was impossible for me to avoid it. I eventually began to eat very little, stopped doing the things that I enjoyed, and began asking my mother question after question about the possible sinfulness of various things I had done. Eventually, my mother suggested that perhaps I should no longer attend Catholic school, because she felt that this might be causing my problem. Therefore, I stopped talking about my thoughts and questions, so that I would not have to change schools. I know now that this was the beginning of my scrupulosity. The degree of difficulty that this has caused me has waxed and waned over the years. However, in my teenage years I realized that there was no way that I could ever live up to the standards that my Church had set up for "getting into heaven." I tried so very hard to do the right thing, but I eventually wished that I had never been born, because I knew that my fate was sealed.

It wasn't until I was in college, tortured by sinful thoughts, that I sought professional help. I learned that I had Obsessive Compulsive Disorder, but not much explanation was given. Therapy was not very helpful, because there was no medication for OCD at the time and little was known about how to treat it. I spent four years trying to keep bad thoughts out of my head and ruminating over how sinful the things that I did were. I always got along well with my peers and enjoyed being with them, but I realized that I could not live my life like other people. I realized that I either had to be in class, attending mass, eating, or studying in the

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New Developments in the Treatment of Impulse-Control Disorders

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The phenomenal progress that forged ahead during the 80's through 90's in both the behavioral and pharmacological fields in OCD has delivered what the patients have been looking for: lessening of their agony and pain. As late as two decades ago many in psychiatry believed that OCD was a rare disorder and untreatable. A combined effort by funding agencies, news media, practitioners and researchers, and the OCF has successfully disseminated emerging diagnostic and treatment information in this field that has led to the widespread understanding of what OCD is and how it can be treated. Many readers of this newsletter provided financial and other supports for the cause. As exciting as the progress has been up to this time, real

progress is yet to be made. Many OCD patients and their families are still struggling with unbearable anguish.

Recently, investigators have begun discussing clinical disorders that share certain similarities to OCD. They include Tourette's Syndrome, Body Dysmorphic Disorder, Anorexia Nervosa, Trichotillomania and Skin Picking. Collectively, these disorders have been called OCD spectrum disorders. Some even included Impulse-Control Disorders (ICDs) in this group. Although OCD and the ICDs share similarities, there are significant differences between these disorders. Unlike ICD patients, OCD patients are not generally impulsive. OCD patients hate novelty. They do not like something new or unexpected. For example, when a person with OCD travels, he tends to prepare in advance so that there will be no unexpected surprises. On the other hand, ICD patients love to explore and encounter risky situations. In time, howev-

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Bulletin Board

Cognitive Therapy for Obsessive-Compulsive Disorder at Harvard Medical School

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
- * 18 to 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, PhD, and Gail Steketee, PhD. If you are interested in further information about this research, please contact Jeannie at the OCD Clinic/Harvard Medical School at (617) 724-4354 or email at jeannie@wjh.harvard.edu.

Research Study of Cognitive-Behavioral Therapy for OCD

The Anxiety Disorders Clinic at the New York State Psychiatric Institute (NYSPI) invites you to participate in a research study of cognitive-behavioral therapy for OCD. Eligibility for participation in the research study includes: 1) currently diagnosed OCD; 2) current use of a medication for OCD; 3) some benefit from an adequate trial of this medication. Study participants will receive at no charge: 1) Exposure and Ritual Prevention Therapy or Stress Management Therapy (Therapy will occur 2X per week for 2 months at the NYSPI in Manhattan); and 2) Medication and Psychiatric visits. Responders will enter a 6-month maintenance phase after therapy. For more information and a confidential screening, please call 212-543-5367.

Also, you may be eligible to participate in a brain scan study as part of a clinical research program. Eligible persons who complete the brain scan study will receive payment for

their time and a psychiatric evaluation at no cost. All calls are strictly confidential. Please call for more information. Anxiety Disorders Clinic at the New York State Psychiatric Institute: 212-543-5367.

University of California, San Diego OCD Genetic Research Study

Genetic research studies aimed at finding genes that contribute to the development of obsessive compulsive disorder (OCD) are being conducted at the University of California, San Diego, in collaboration with other sites in the United States. These studies aim to find the genes that cause OCD using several methods, including examining previously identified genes that are thought to be important in the treatment of OCD.

Participants will complete an interview about symptoms of OCD and related disorders, and will be required to give a blood sample. Participants will receive \$30.00 for their participation.

You may qualify to participate if:

- You have or had obsessions or compulsions that began before age 18
- You do not have bipolar disorder or schizophrenia
- You have at least one parent (with or without OCD) who is willing to participate (give blood and answer a few questions by telephone). Parents do not need to be present at the interview. Each family member who participates will also receive \$30.00.

We are interested in participants from all geographical regions. In many cases, we can travel to you to complete the interview and blood draw. We are particularly interested in participants who have other family members with OCD. We are particularly interested in participants who are of Ashkenazi Jewish descent. Although OCD is not more common in this population, genetic similarities among people from this group make it easier to find a gene for OCD.

This study is being conducted by Dr. Carol A. Mathews, M.D., and colleagues. For more information, contact Laurel Campbell toll free at 1-866-864-8909, or via e-mail at ocdstudy@ucsd.edu.

Research Project on Changes in Thinking

We are looking for participants for a research project conducted by Dr. Julie C. Stout, an associate professor in the Department of Psychology at Indiana University, Bloomington. The goal of this project is to

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OCD NEWSLETTER

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

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

Dr. Foa's Center: Where It All Began

The OCD NEWSLETTER interviewed Elna Yadin, Ph.D., the OCD Clinic Coordinator, at the Center for Treatment and Study of Anxiety, Department of Psychiatry, The University of Pennsylvania Health System. This is the Center headed by Dr. Edna Foa, one of the pioneers of the use of Cognitive Behavior Therapy in the treatment of OCD and other anxiety disorders.

NEWSLETTER: Dr. Yadin, Dr. Edna Foa, the director of the Center for Treatment and Anxiety, has been in the forefront of Cognitive Behavior Therapy (CBT). What led her to use CBT to treat anxiety disorders and OCD?

DR. YADIN: Dr. Edna Foa was influenced and motivated by her work with Dr. Joseph Wolpe and by her interest in the application of evidence-based cognitive behavioral treatments for anxiety disorders.

NEWSLETTER: Was Dr. Foa's the first intensive treatment program for treating OCD with CBT? How was it designed?

DR. YADIN: The Intensive Treatment Program for treating OCD with CBT was introduced in the mid 1960s by the British psychologist, Victor Meyer. Since its introduction, the treatment has undergone considerable modification and refinement; both in Britain by Dr. Isaac Marks, and in the U.S. by Dr. Foa. It has been implemented in clinics and in research studies. These developments have resulted in greater awareness about OCD and about the availability of treatment programs for OCD among mental health and general health professionals, as well as in the public at large.

NEWSLETTER: Does the present Intensive Treatment Program at the Center for the Treatment and Study of Anxiety at the University of Pennsylvania differ much from the original program? How?

DR. YADIN: The Intensive Treatment Program at the Center for Treatment and Study of Anxiety at the University of Pennsylvania (CTSA) is a 3.5-week regimen of individual daily two-hour sessions of exposure and response prevention. The program includes 17 sessions and incorporates additional home visits as deemed necessary. The focus of the first sessions is gathering information, monitoring the symptoms, and creating a treatment plan. The focus of the remainder of the sessions is on exposure and ritual prevention, on relapse prevention, and on future planning. The Intensive Program is for those persons who come to Philadelphia from out of town, for the more severe cases, or for people who have taken time off from work or school to focus on treatment. It has recently been expanded to offer the same options to adolescents and children.

NEWSLETTER: Could you describe how CBT is used to treat OCD and OC Spectrum Disorders? Why does CBT work?

DR. YADIN: CBT addresses a multitude of issues. It has a large psychoeducational component that teaches OCD sufferers and their families about the myths and truths (as we currently know them) regarding OCD. It helps the sufferers identify their triggers, their obsessions, and their compulsions. During CBT, patients are taught how to gradually expose themselves to fear-evoking stimuli and how to engage in ritual prevention. They find out by practicing the exposure and response prevention exercises that their anxiety eventually decreases without the need for a ritual, which in turn results in a further gradual decrease of the obsessions. It has been found that some OC Spectrum Disorders, such as, Body Dysmorphic Disorder (BDD) and Hypochondriasis respond well to the CBT used for OCD, while others are not amenable to this approach.

NEWSLETTER: What part, if any, does medication play in your treatment program?

DR. YADIN: Many people seeking CBT for OCD come to us already on medication. Whenever possible, we work in coordination with the prescribing physician. If the patient expresses interest in consulting with a psychiatrist within the University of Pennsylvania Health System we make a referral to our colleagues at the Mood and Anxiety Center on a case-by-case basis.

Research studies have shown that the effectiveness of CBT for OCD is independent of medication. Therefore, patients receive exposure and response prevention treatment whether they are on medication for OCD or not at the time they come for treatment.

NEWSLETTER: Do you use any other treatment modalities?

DR. YADIN: We make use of cognitive behavioral techniques within the context of exposure and response prevention. So, for example, we use psychoeducation, data gathering, risk assessment, and experimentation. In addition, although we do not do formal family therapy, in many cases we involve other members of the family, either as coaches, and, more often, as recipients of the psychoeducation about OCD.

NEWSLETTER: Can you describe the complete treatment program at your Center? What treatment regimes does it encompass?

DR. YADIN: The CTSA offers both study and non-study treatment programs for a variety of anxiety disorders (OCD, PTSD, Social Anxiety, Trichotillomania, Panic, Specific Phobias). For information and eligibility requirements on all available programs, patients should log onto the CTSA website or call the Center. As for the OCD program, in addition to the Intensive Treatment Program, we offer similar treatment with a less frequent regimen, such as, twice a week or once a week, depending among other considerations on schedule and convenience to the patient. A determination of the recommended schedule is made

during a thorough pre-treatment evaluation.

NEWSLETTER: Do you have a set program or is there a unique treatment plan developed for each patient?

DR. YADIN: The treatment plan is tailored individually to each patient. Although there are many similarities among OCD profiles, each person may manifest the symptoms in a unique way and has his or her own set of circumstances.

NEWSLETTER: Who should consider enrolling in your treatment program? People with very severe, severe or moderate OCD?

DR. YADIN: Any person with OCD may consider enrolling in our treatment program. We have treated patients within a wide range of severity, from ones with incapacitating OCD to persons with symptoms in the sub-clinical range, who wanted to "nip their OCD in the bud." Obviously, the length of treatment and the frequency of sessions will vary depending on the need, and will be determined by the treating clinician in consultation with the patient.

NEWSLETTER: Does your program have a set duration or is it tailored to the individual needs of each person? If so, how long is the treatment program?

DR. YADIN: As mentioned above, the treatment program is typically 17 two-hour sessions, with an option for one or two additional sessions for home visits. On occasion, fewer sessions are required. After completion of the treatment, patients are encouraged to continue practicing what they have learned because additional gains are often made in the period after treatment. Occasionally, patients will opt to come back for several booster sessions, as needed.

NEWSLETTER: The Center's program is "intensive." What does that mean?

DR. YADIN: Although we offer less intensive programs for treatment of OCD, the CTSA is mostly known for its Intensive Program. In the intensive treatment program the patient and therapist meet for individual two-hour sessions, five days a week; and the entire treatment plan is completed within 3.5 weeks.

NEWSLETTER: How do patients adjust to an "intensive" program? Do you start gradually with new patients, building up day by day? How do patients acclimate themselves?

DR. YADIN: The general principles of the intensive program are discussed with the patient at the end of the evaluation during which the recommendation for the program is made. The first two sessions of the intensive program are aimed at rapport building, information gathering, careful monitoring of the OCD characteristics of the individual patient, and the building of a comprehensive hierarchy for exposure and ritual prevention. The exposure exercises are a collab-

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New Developments in the Treatment of Impulse-Control Disorder

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er, the two disorders begin to share important behavioral attributes. For example, they both may develop rituals that they feel compelled to engage in even if they don't want to. These include repetitive washing, checking, arranging rituals for OCD patients and uncontrolled gambling, shopping, stealing behavior (items that one does not even need) for ICD patients.

During the past 6 years, parallel to our OCD research, we have been engaged in the search for an improved treatment for pathological gambling disorder and kleptomania. In the OCD area we have worked closely with Dr. Matt Kushner, an exceptional behavior therapist in our department. We are working closely with him in the treatment of ICDs as well. We now have an Impulse-Control Disorder Clinic in the Department of Psychiatry, University of Minnesota Medical School where we treat ICD patients.

Currently, investigators are involved in the evaluation of various SSRIs in the treatment of ICDs (Pathological Gambling Disorder, Compulsive Shopping, Kleptomania). Currently, investigators at the University of Iowa are testing bupropion (Wellbutrin) in the treatment of pathological gambling disorder. Investigators are also working to improve on the behavior therapy of pathological gambling disorder.

Recently, a multicenter paroxetine (Paxil) treatment study of pathological gambling has been completed in the U.S. A multicenter treatment study of a novel compound (non SSRI) is currently underway to evaluate the safety and efficacy in pathological gambling disorder. Investigators in several institutes are currently involved in epidemiological, genetic and brain imaging studies involving pathological gambling disorder.

Our primary focus has been to find a way to reduce human urges or craving symptoms. After evaluating six different compounds (SSRIs, bupropion, isradipine, cyclobenzaprine, ondansetron and naltrexone) we decided to work on naltrexone. From the beginning we departed from the traditional treatment approach used by the alcoholism researchers. These researchers targeted any patients who met the diagnostic criteria for alcoholism. We specifically targeted only the ones who had strong craving symptoms. In the case of gamblers we treated only the ones who had cravings for gambling. For example, if someone was gambling to escape from depression or loneliness we did not treat the person with naltrexone. Secondly, we used a higher naltrexone dose than the dose used for alcohol treatment. We thought naltrexone 50 mg/day was insufficient to control human urges. In a series of studies we proved this to be true in the case of pathological gambling disorder and kleptomania.

We found the same results in alcoholism in our clinical practice. Patients needed 100 to 150 mg/day, not 50. Again, if we treated alcoholics, we treated only the ones who had strong urges to drink alcohol.

There has always been a major barrier in using naltrexone clinically. The problem was that at higher than 50 mg/day, naltrexone caused liver enzyme elevations. We found that a reason for these increases was because of concurrent use of over-the-counter (OTC) analgesics (Motrin, Advil, aspirin, Tylenol, Alka-Selzer; cold medicine) with naltrexone. When we began to use high dose naltrexone, we too found elevated liver enzymes in a substantial number of subjects. When we examined their charts, we found out that all of them were on OTC pain medicines. When we restricted OTC pain medicines, enzyme elevations became a rare event. We reported this finding and began to collect data on the subject. Our most recent outpatient clinic data involving 50 patients showed that liver enzymes did not increase at all if the patients refrained from using OTC analgesics. If enzyme elevations did happen, we either reduced the naltrexone dose or stopped the drug. Then liver enzyme levels returned to normal without exception. This finding allowed us to use a higher dose. We then found a significantly more effective treatment outcome. Most of our patients liked the treatment results very much because they found themselves in control of their craving symptoms. They reported to us that they no longer had to fight against their unwanted urges.

Naltrexone does not stop all craving symptoms. For example, naltrexone does not reduce nicotine craving or appetite craving symptoms. Most patients do not lose their sexual desire; but we found that patients who have pathological sexual urges respond well to a high dose naltrexone. Using our new approach we have been able to treat a number of severe alcohol and sexually addicted cases with naltrexone.

In our published reports we have described the rationale for using naltrexone in the treatment of ICDs. We explained the reasons why and how naltrexone works in the brain. Within the brain there is an opioid system or circuits in which a brain opiate substance called endorphin plays a vital role. One of these circuits enables us to experience excitement and pleasure when we anticipate/encounter incentives or receive rewards. The other circuit controls physical pain. We will limit our discussion to the pleasure subject and the circuit that processes pleasure. Endorphin is a protein molecule made in the brain. Endorphin works very much like morphine although their chemical structures are totally different. Morphine

comes from a poppy (joy) plant. Morphine is an opium alkaloid named after the Greek God of dreams Morpheus. Opium means juice, it comes from the juice of poppy capsules. People abuse opium because as soon as opium reaches the brain (some directly and some through the vagus nerve) circuit mentioned above it relieves the person from mental anguish or depression almost instantly. Additionally, it brings about intense euphoria. The effect is so dramatic many are compelled to go back to it. It's almost like a teenage boy or girl, having found a loved one, becoming enslaved by the infatuation. Pretty soon the individual gets habituated to it and can't get away from it.

Naltrexone blocks these morphine or endorphin effects. If one takes naltrexone first and then takes morphine, one no longer feels euphoria. Naltrexone not only cuts off the pleasure effects but the person's craving symptoms as well. The unique aspect of our finding is that naltrexone does not do this effectively until the dose reaches 150 mg/day. Also, to see the effect, naltrexone should be used only for those who have craving symptoms. As stated before, if someone gambles because of psychological distress or depression, naltrexone is unlikely to be of help. Naltrexone itself is not addictive so one can take this drug without worrying about getting addicted to it. Naltrexone does not affect normal motivation or pleasure. In our clinic, we treat patients for 2-3 years and if everything looks good we attempt to discontinue the drug. If the patient continues to do well without naltrexone, we do not restart the medication. If not, we resume naltrexone another 3-6 months and reevaluate. The most important information is that one cannot use naltrexone along with OTC pain medicines. As mentioned previously, if liver enzyme levels do go up discontinuing naltrexone will correct the problem.

Naltrexone often causes nausea and loose stools for the first three days of taking the drug. We often use a nausea medicine (ondansetron or compazine) for the first 2-3 days to protect the patient from this side effect. We also combine one of the selective serotonin receptor blockers (Paxil, Zoloft, Prozac, Luvox, Celexa or Lexapro) to naltrexone because many patients have subtle depressive symptoms along with their addictive behaviors.

In contrast to OCD, many gamblers, compulsive shoppers, and kleptomaniacs do not come forward for treatment because they do not want to give up the source of their pleasure. These patients often come to us only after they have exhausted all of their resources. Recently, we found out that two factors influence treatment outcome the most. One is that if a person has someone in the family who is concerned about the patient's illness the treatment outcome is more favorable. Another finding was that an improvement, even if small, during the early phase of the treatment tends to encourage patients to stay in the program.

Sin Lurked Everywhere

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library until it closed, because this was the best way for me to escape from thoughts and people, and, hopefully, prevent myself from sinning. This became my way of living for many years to come.

Upon returning home from college, things got worse. I found that I could no longer decide if I was in the proper "state of grace" to receive communion. I went over and over the rules for mortal sin. Was the sin a grievous offense? Did I give it proper reflection? Did I give full consent of my will? Then I found myself having sexually religious thoughts when I received communion. I had no choice, but to give up receiving this sacrament. Church was a difficult place for me to be, because it often brought on tormenting thoughts; but I had to be there. I would be sinning if I missed mass on Sunday.

Over the years my OCD has taken many different forms, many of which are in some way related to my religion. Unfortunately, for a very long time I did not know that what was happening to me was all part of this illness. I thought of myself as a very evil person. It also affected me physically. I lost feeling in my hands and face for over a year. This was brought on by my belief in the sinfulness of my thoughts and my belief that I deserved to be punished with some grave illness.

I decided that going to confession was mandatory at Christmas and at Easter. Receiving this sacrament had always been hard for me, but it eventually became a torture. I would look at lists of sins that people could commit and try to decide if I had committed them. I could often not decide; so to avoid making a bad confession, I decided that I had probably committed just about all of them. Then when I heard that the worst sin was blaspheming the Holy Spirit, I decided it had to be added to the list too. I couldn't figure out what it meant, but I had to include it in case I had done whatever it was and just wasn't aware of it.

I also worried that there might be a "right" order for these sins to be confessed. I never could decide if the worst should go first or last. I wrote down my list of sins in what I hoped was the "right" order and then memorized the list. I repeated it over and over in my head, so that I would not forget anything. I always hoped that the priest would not ask me anything about any sin, because it might confuse me in the recitation of my list. There was also the problem that I could be asked about a sin that I didn't know if I had really committed. I couldn't lie, but I didn't know how I would explain that this was a possible sin that I had committed.

After leaving the confessional, I would worry that the priest had not understood everything that I had said, or that I had not expressed it properly. I also had to worry about if I was sure about the penance I had received. Usually, the

penance was to say some prayer a certain number of times. That sounds easy enough, but I was never sure that I had counted right. Also, a prayer didn't count if my mind drifted while I was saying it. It was a major task for me to keep my mind focused, so you can imagine how difficult it was to recite a prayer a specific number of times.

When a neighboring parish starting having Communal Reconciliation Services with general absolution, this became for me the only time that I actually experienced the meaningfulness of the sacrament. Of course, the bishop stopped these services, because they were against canon law. A few times when I would then go to communal services with individual confession, they would ask each person to come up and tell the priest one thing that they felt that they needed to work on to become a better person. This was still a problem. How could I know for sure, which was the "right" sin to confess? Was I picking an easy one? I had to decide which sin was the worst, and then I had to be sure that I phrased it properly so that it did not sound less sinful than it really was. With this format for confession I had a lot less things to be sure about, but everything rested on picking the "right" sin.

The solution to my problem came while attending a workshop at one of the OCF Annual Conferences. Dr. Ciarrocchi was speaking about scrupulosity and the problems of receiving the sacrament of Reconciliation. He mentioned that a pastoral decision could be made to apply *epikeia* for any person for whom confession brings out scrupulosity. This dispensation means that the person need not go to confession or that she could celebrate the sacrament in a way that was meaningful for her.

The next time I went to receive the sacrament and ever since then I tell the priest that I have OCD and that one of its manifestations for me is in the form of scrupulosity. Therefore, I want to apply *epikeia*. Sometimes I have to explain what I am talking about, but every priest has always been accepting of this. I simply state that I have done things wrong, that I am sorry, and I intend to try to be a better person. I am given absolution, and I feel touched by the grace of God.

The torture of the experience no longer exists. Most people I know have never heard of this, but it has sure made a difference in my life. I am no longer as scrupulous as I once was; but it is still a major issue for me at times. A priest knowing of my scrupulosity fairly recently gave me an "Easy Pass" to just go out and live life. I must admit that there is a comfort in having the "Pass," because some of the responsibility for its use falls on the priest who gave it to me. However, I am still a Catholic with scrupulosity, so living life is serious business even with an "Easy Pass."

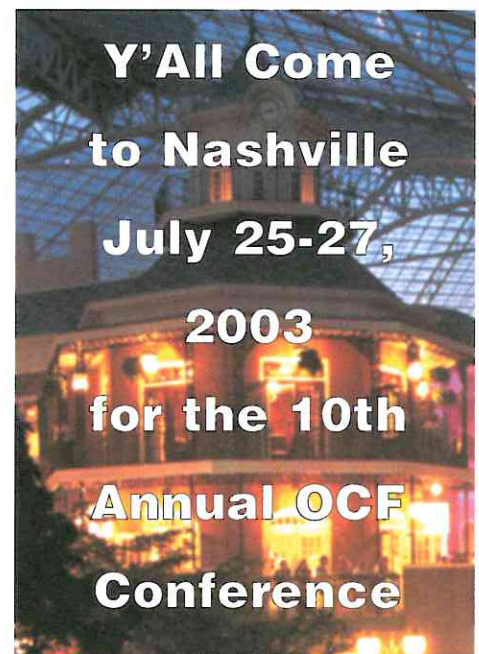
Scholarships for Patients

The University of Illinois at Chicago has recently been awarded a grant by the Office of the Attorney General of Illinois through the Mylan Anti-Trust Settlement. A large portion of this grant will be used to fund scholarships for patients of the Obsessive-Compulsive Disorders Clinic at UIC. The grant will allow the OCD Clinic to provide a subsidy for time limited, outpatient treatment for qualified Illinois residents.

The OCD Clinic at UIC offers state-of-the-art psychotherapy and medication services for adults with Obsessive-Compulsive Disorder and related conditions. The OCD Clinic specializes in Exposure and Ritual Prevention and Cognitive-Behavioral Therapy, and these services can be provided on an outpatient, intensive outpatient, or inpatient basis.

Distribution of the scholarships will be based on both financial need and clinical appropriateness. Once analysis of the applicant's available economic resources has been completed and financial need established, each application will then be reviewed by the OCD Clinic team who will examine a variety of factors to determine clinical eligibility.

For more information, contact either Dr. Cheryl Carmin or Dr. Pamela Wiegartz at 312-355-3000, option 2.



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 neurosurgical treatment of OCD. Neurosurgery (also referred to as psychosurgery) is the selective surgical removal or destruction of nerve pathways for the purpose of influencing behavior (1976 definition by the World Health Organization).

Nonpharmacological somatic treatments of anxiety disorders

Primary Psychiatry, 9:55-58, 2002, H.E. Ward, N.A. Shapira and W.K. Goodman

This is an excellent review of four treatments: neurosurgery, deep brain stimulation (DBS), vagus nerve stimulation (VNS) and repetitive transcranial magnetic stimulation (rTMS). Neurosurgery is the creation of lesions in the brain and several techniques are used.

Cingulotomy is the most common procedure in the U.S. Response rates vary from 35% to 65% for OCD. DBS has been successfully used to treat essential tremor and Parkinson's disease since about 1995. There are reports of benefits for OCD and investigations are in process. DBS uses an electrical current from implanted electrodes to disrupt neural transmission in specific brain regions; this disruption is reversible. VNS was approved by the U.S. FDA in 1997 for treatment-resistant epilepsy and involves implantation of a pulse generator that is similar to implantation of a pacemaker. The generator, about the size of a pocket watch, is implanted under the skin in the chest wall and stimulates the vagus nerve that runs from neck to the brain. VNS is currently under investigation for OCD but response data are not yet available. Least invasive, rTMS delivers electrical stimulation on the surface of the brain from an electromagnetic coil placed on the scalp. It has shown promise in depression, but findings have been mixed in anxiety disorders.

Review of long-term results of stereotactic psychosurgery

Neurologia Medico-Chirurgica (Tokyo), 42:365-371, 2002, M.C. Kim, T.K. Lee and C.R. Choi

This is a follow-up study of 21 patients treated surgically for severe treatment-resistant psychiatric disorders in Seoul,

Korea. Of interest, 12 patients had OCD and all 12 patients benefited from the neurosurgery. A dual-lesion technique called limbic leucotomy, a combination of cingulotomy with subcaudate tractotomy, was performed for OCD. Substantial improvement was seen at six months and further improvement was seen in longer follow-up. Ten of the OCD patients could be followed up (1 to 7 years with an average follow-up time of 45 months). Response was measured with the Yale-Brown Obsessive Compulsive Scale (YBOCS) and average YBOCS scores declined dramatically from 34 to 3 for those patients followed up. These researchers conclude that psychosurgery is a safe and effective method of treating some treatment-resistant psychiatric illnesses, including OCD.

Compulsions, Parkinson's disease, and stimulation

Lancet, 360:1302-1304, 2002, L. Mallet, V. Mesnage, J.L. Houeto et al.

Electrodes were implanted in the thalamus of the brain to alleviate parkinsonian symptoms in two patients with Parkinson's disease and severe OCD. Both patients had suffered OCD before developing Parkinson's disease; one had a 33-year history of OCD with a 5-year history of Parkinson's disease and the other had a 40-year history of OCD and 16-year history of Parkinson's disease. The Parkinson's disease symptoms improved in both patients and additionally their compulsions disappeared and their obsessive symptoms improved. One patient, 2 weeks after surgery, claimed she was more pleased with the disappearance of her OCD symptoms than with the moderate improvement in her Parkinson's disease. The improvements in these two patients suggest that deep brain stimulation in the thalamus could benefit other patients with severe treatment-resistant OCD.

Neural implants and obsessive-compulsive disorder

Psychiatric Times, 20:43-44, 2003, J. Medina

Following a quick review of the neurobiology of OCD, Dr. Medina discusses deep brain stimulation. Electrodes are surgically implanted into specific regions of the brain and connected to an external stimu-

lator. The procedure is reversible as the electrodes can either be physically removed or the stimulator switched off. Small studies in Europe and the United States have shown high response rates and early benefits. Many questions are still to be answered, i.e., how long will the positive effects last and, most importantly, are there any harmful effects from long term electrical stimulation of the brain.

Deep brain stimulation for psychiatric disorders

Neurosurgery, 51:519, 2002, OCD-DBS Collaborative Group

Top investigators of psychosurgical treatments for OCD have formed an international group, the OCD-Deep Brain Stimulation Collaborative Group. In order to emphasize to neurosurgeons that deep brain stimulation is investigational and not standard practice for mental disorders, the group has published this letter. They urge investigators to form multi-center teams to systematically study deep brain stimulation (DBS) in OCD. Several other recommendations were given, including the recommendation that DBS should be conducted at or supervised by a clinical research center. They conclude that DBS has the potential to be a treatment for severely ill patients, but research should proceed cautiously.



A Parent Can't Sit and Wait

by Laura McAmis

Squeals of bus brakes and snatches of students' conversations drifted into the second story window of the waiting room off Miller Avenue. Thin afternoon light streaked across the hardwood floor and climbed the frayed couch where I sat, listening to the rhythmic thud of the basketball my son tossed through a plastic hoop attached to his psychiatrist's door. Slumped into the depression my body made in the springless couch, I sipped my luke-warm latte.

As a five-year-old, Scott's passion had been Brio™ train sets. He would sit on the living room floor, gangly legs folded at sharp angles beneath him, surrounded by loops and arches of the train tracks. His greatest fear was that his younger sister would toddle over to his masterpiece and "help." But, about the time of his sixth birthday a new, all-encompassing fear gripped him.

As I cooked dinner at the stove he came to me with outstretched arms pleading, "Check my hands, Mommy. I think they have pee on them." Cursorily sweeping my hands over his, I pronounced them clean. A short time later he was back in the bathroom meticulously washing the "pee" off and begging more reassurances.

Days later he shrieked as his three-year-old sister approached, "Don't let her touch me. She's got pee on her." Grabbing his shoulders I shook him. "Stop that, Scott. You know she doesn't have pee on her." "She does," he said, dissolving into sobs.

Scott retreated to his room to protect himself and his toys. I reached for the phone to find a child psychiatrist.

Within days my husband and I were perched on the edge of the leather couch in the doctor's office seeking help with our son's strange behavior. Stretched out on a leather recliner, Dr. N. listened to our concerns and recommended that we bring him in for psychodynamic therapy. Above him hung framed degrees from Harvard.

Bookshelves with thick volumes of child psychiatry lined the walls. My husband and I quickly nodded in agreement. As we left the office I said, "This is just a bump in the

road. He'll get over it quickly."

During the next year Scott and I sat in that waiting room every week. Dr. N. would open the door, Scott would enter and remerge fifty minutes later. The analytic tools I glimpsed through that door consisted of "Life," a game board, and a nerf basketball that lay on a shaggy carpet. Occasionally, Dr. N. later phoned us to say, that all was "going well."

However, I did not see such optimistic progress at home. Scott's hands were chapped and raw. His Brio™ trains lay in a jumble in a box. He curled up in a ball on the floor. Tears slid down his face when he asked, "Mommy, why do I worry? Will I ever stop?". I held him, stroked his curly blond hair and murmured reassurances as sharp pains stabbed me through the stomach.

Late one evening, as I folded laundry, a T.V. newsmagazine show, "20/20", featured a man who feared his hands were contaminated by dirt and was compelled to repeatedly wash them. The doctor said his patient had Obsessive Compulsive Disorder. Treatment included medication and behavioral therapy, repeated exposures to the dirt and cessation of the washing ritual. The laundry lay piled in my lap. I stared at the T.V. stunned in shock and recognition.

When I asked Dr. N. if he thought that Scott suffered from Obsessive Compulsive Disorder, he told me he had considered the possibility, but still felt he was on the right track. He also expressed concern that if Scott took medication, he would be less amenable to psychotherapy.

The basketball stopped thudding. I continued to sip my latte on the frayed couch with my back to the psychiatrist's door. Tattered copies of People magazine that I flipped through on previous visits were strewn on the table. The door behind me clicked open. Fifty minutes were not up. I knew Scott would be going to the bathroom to wash his hands. Following him was Dr. N. He squatted before me, tie loosened at his neck, eyeglasses slipping down his nose. "We're making progress. I think we had a breakthrough today."

This time I was not so easily lulled

into accepting his reassurances. Although I wanted to believe a breakthrough was imminent and Scott could be cured, I also knew we were losing precious time during crucial years of development. I needed to stop waiting and start exploring other options. I called the Stanford Obsessive Compulsive Disorder Clinic for an appointment. A few weeks later one of the psychiatrists there administered a diagnostic scale and confirmed our suspicions. Scott had OCD.

My husband and I shed our passive wait-and-see attitude towards his treatment and took him to Stanford where he started medication and behavioral therapy. We began to see dramatic results.

I no longer hope for a breakthrough. I know that there is no cure, but with hard work on everyone's part Scott has succeeded. He became a National Merit scholar, was admitted to college, plays for his school's lacrosse team and takes medication for OCD.

I also learned about myself. While there are many gifted professional people who can help parents with troubled children, only the parents who are with that child 24/7 can orchestrate his or her care. I don't sit on couches in waiting rooms anymore.

3rd Annual OCF Film Festival

It may not be Cannes or Sundance yet, but we are looking for films for the 3rd Annual OCF Film Festival.

We are looking for films by directors with OCD or an OC Spectrum Disorder, and/or about OCD or films that deal with the OC Spectrum Disorders – features, documentaries or shorts.

If you are interested in having your film considered for the 3rd Annual OCF Film Festival at the Annual OCF Conference in Nashville, TN on July 26, 2003, contact Patricia Perkins at 203.315.2194 or perkins@ocfoundation.org for more information.

Dr. Foa's Center

(continued from page 3)

orative product between the therapist and the patient, with the first exercises typically tailored in such a way so as to achieve successful reduction of anxiety without ritualizing. The patient is then encouraged to go up his or her hierarchy at a steady pace and to confront even the worst of the items within the course of the treatment.

NEWSLETTER: What happens on a patient's first day in the program?

DR. YADIN: On the first day of the program the patient meets his or her therapist and the process of information gathering begins. This includes a recap of the patient's history and mapping of OCD internal and external triggers, avoidances, obsessions and compulsions. The patient is asked to closely monitor and record the obsessions and the compulsions during the following days in order to create the exposure hierarchy.

NEWSLETTER: Can you describe a typical day in the program?

DR. YADIN: The exposure sessions typically consist of selecting a trigger (which can be a situation, an object or a thought) that is at the next level of anxiety to be confronted and tailoring an exposure exercise to address it. In tailoring the exposure exercises, the interests of the patients are often taken into consideration. So, for example, if a person concerned with accidentally harming by bumping into someone is interested in art, the exposure session can take place at the local art museum. Or if a child is worried about contamination by dirt, the exposure session can take place in a playground. To quote one of our pediatric patients: "I didn't know that therapy can be fun!"

NEWSLETTER: Can you describe a typical course of treatment in your program? Where does a patient start with CBT and where do you expect him or her to be at the end of the program?

DR. YADIN: The CBT program begins at whatever level of OCD the patient comes in with. Regardless of severity, information gathering and creation of the individual hierarchy are the first step. At the end of the program we expect the patient to have experienced a significant reduction of symptoms. It would be difficult in this context to describe a specific course of treatment for a particular patient. In general, especially in pediatric cases, the process would include mapping of the OCD, choice of targets, introducing interim steps to achieve the higher exposure goals, externalizing of the OCD, and teaching loved ones to provide support and comfort when the patient is anxious without providing ritualistic reassurance.

NEWSLETTER: The Center's program is "intensive," but not residential. What facilities are available for individuals who do not live within daily commuting distance of the Center?

DR. YADIN: The CTSA's program is conducted on an outpatient basis. For individuals and families who do not live within commuting distance of the Center and who would prefer not to stay at

nearby hotels, there is a network of hosting families providing in-home hospitality. For more information about this non-profit organization, patients should contact Hosts-for-Hospitals directly at 610-660-6667 or visit the website: hostsforhospitals.com

NEWSLETTER: Who can be in your program? Adults? Adolescents? Children?

DR. YADIN: Our program accepts adults, children and adolescents. All patients undergo a thorough evaluation before treatment options are discussed.

NEWSLETTER: Do patients in your program meet and work together with each other over the course of the program?

DR. YADIN: Patients in our program do not typically interact with each other. On occasion, however, we have had individuals or families who had gone through the program and who have expressed an eagerness to share their experience with others contemplating the program meet. This is mainly to offer them encouragement and hope.

NEWSLETTER: Do you have group therapy? Support groups?

DR. YADIN: The CTSA does not offer group therapy, nor do we have support groups. There are, however, several support groups for OCD sufferers in the Philadelphia area. A listing is provided on the OC Foundation website.

NEWSLETTER: OCD is a chronic illness. What kind of relapse prevention program do you have?

DR. YADIN: Relapse prevention is built into the treatment program. From the initial contact, it is clear to patients that they will learn to manage their OCD rather than to affect a cure, much like others manage a disease, such as, diabetes. They are taught to identify their own lapses and to correct them by tailoring appropriate exposure and ritual prevention exercises. With some patients, especially with younger children, we may set up a checkup appointment a few months after completion of the treatment program to assess their continued progress and their maintenance of gains.

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

DR. YADIN: Involvement of family members and significant others in the right way is an important aspect of the treatment of OCD. In most cases, before treatment, family members are very much affected by the OCD, whether by being recruited into doing the rituals or by witnessing the anxiety and distress accompanying the disorder. In treatment, we teach family members how to keep out of the obsession-compulsion cycle on the one hand, while providing support and encouragement on the other. They are often able to help the patient best by being a "coach," that is, someone who accompanies the patient on the exposure and ritual prevention exercises. It is very helpful for both the patient and the family members to remove OCD from the focus of the relationship.

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

DR. YADIN: The CTSA has a clinical staff of 13 Ph.D.-level therapists. In order not to compromise the quality of care, each clinician is involved in one intensive treatment program at a time, in addition to working with a variety of other patients in less intensive programs.

NEWSLETTER: Who are the treatment providers in your program? What are their academic and professional backgrounds?

DR. YADIN: All of our treatment providers are CBT therapists who have been trained to work with OCD at the Center, which is directed by Dr. Edna Foa. Space does not permit the listing here of all the academic and professional backgrounds. However, information on the individual therapists' credentials can be found on the CTSA website.

NEWSLETTER: How successful is your program?

DR. YADIN: Statistically, 70-80% of patients completing the treatment program achieve a clinically significant improvement in their OCD symptoms. Although we do not speak of patients as being cured, they complete the program with their OCD under control and they are armed with the tools that will help them to maintain their gains and, in many cases, to avoid major relapses.

NEWSLETTER: What kind of follow-up care do you provide for program participants?

DR. YADIN: In most cases, after completion of the treatment program, we follow up with weekly phone calls for several weeks. Patients are told that if they encounter difficulties implementing the principles of the treatment in their natural environment they are welcome to contact their therapist and, if needed, to schedule a booster session or two.

NEWSLETTER: Do you treat individuals who have co-morbid conditions or substance abuse problems?

DR. YADIN: We treat individuals with co-morbid conditions that are not incompatible with the OCD treatment. For example, children with OCD who may also have Attention Deficit Hyperactivity Disorder (ADHD), or Tourette's Syndrome can receive effective CBT for their OCD. On the other hand, when the co-morbid condition is primary and likely to interfere with the OCD treatment, we refer them to our open clinic for treatment of other anxiety disorders or make the appropriate referral to another facility. Thus, a patient with major depression is referred for treatment of the depression before OCD treatment can commence. Similarly, substance abuse is incompatible with the exposure model of OCD treatment and the patient is encouraged to seek treatment for his abuse problem first.

NEWSLETTER: Do you treat people with OC Spectrum Disorders in your program?

DR. YADIN: We do indeed treat adults, adolescents and children with OC Spectrum Disorders in our open clinic (non-study). Dr. Martin Franklin is also heading a research trial for children ages 7 to 17 with Trichotillomania.

NEWSLETTER: How do you handle the situation where a person's rituals are centered at his home or place of work?

DR. YADIN: It is extremely beneficial to conduct home visits, especially when a person's rituals are centered at his or her home. This is particularly true for hoarders, although not exclusively so. In cases where home or office visits are impractical or impossible, patients are encouraged to bring in to the session items from their home or office for the exposure exercises.

NEWSLETTER: What types of research are going on at the Center? Can patients be involved?

DR. YADIN: Currently, in addition to the pediatric Trichotillomania study mentioned above, the CTSA is conducting an NIMH-funded collaborative study that examines the potential benefit of augmenting SRI treatment with CBT for OCD patients with residual symptoms. For further information and eligibility requirements, patients may contact the Center.

NEWSLETTER: What other treatment options do you have available at the Center? A less intensive program? A partial program? An in-office weekly program?

DR. YADIN: As mentioned earlier, the Center offers a variety of treatment options in addition to the intensive program. These include twice weekly or once weekly sessions. Treatment schedules can be flexible and are determined collaboratively between therapist and patient.

NEWSLETTER: Can you admit patients on an emergency basis into your program?

DR. YADIN: The CTSA is an outpatient facility. We aim to accommodate the patients' needs and we try to schedule them for treatment with the shortest possible wait. However, we do not accept walk-ins on an emergency basis.

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

DR. YADIN: Since insurance coverage varies widely among insurers, patients are encouraged to contact the CTSA's business administrator, who will assist them in sorting out the financial arrangements.

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

DR. YADIN: Once again, it is best to contact either the business administrator of the CTSA or me, the OCD Clinic Coordinator, to discuss all the available options.

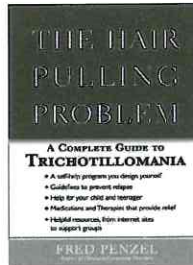
NEWSLETTER: If someone is interested in enrolling in your program or wants more information, whom should s/he contact and how?

DR. YADIN: Inquiries about the OCD programs available at the Center for Treatment and Study of Anxiety can be made either by phone 215-746-3327, or by e-mail ctsa@mail.med.upenn.edu.

A Review of "The Hair Pulling Problem: A Complete Guide to Trichotillomania,"* by Fred Penzel

by Douglas W. Woods, Ph.D., University of Wisconsin-Milwaukee

I am a psychologist who has dedicated his career to researching and treating tic disorders, Trichotillomania (chronic hair pulling), and other body-focused repetitive behaviors like skin picking and nail biting. I know that these problems have a complex origin, that many people have them, and that they can truly impact a person's life. Those who have these disorders (especially Trichotillomania) suffer in isolation and



when they do summon the courage to seek treatment, they are often met by professionals who are uninformed about their condition. The relative lack of information about these disorders for persons suffering from them, professionals who treat them and the lay public is troubling. Thus, I was very happy to be asked to read and review a popular psychology book on Trichotillomania.

Dr. Fred Penzel's book, "The Hair Pulling Problem: A Complete Guide to Trichotillomania," is an accessible, comprehensive, sensitive, and scientifically accurate look at Trichotillomania, a silent and potentially devastating disorder. Not only does the book do an excellent job of summarizing and explaining the current thinking about and approaches toward treating Trichotillomania, but with his discussion on issues of acceptance and mindfulness, Dr. Penzel is in tune with the very latest research on the conceptualization and behavioral treatment of the disorder.

Putting the scientist in me aside, I tried to read the book from the perspective of my patients with Trichotillomania. What would it be like if I were someone who had been living secretly with the problem for 20 years and felt like I was the only one in the world who couldn't stop pulling his hair? What would I feel when I came upon this book and began to read? The answer...relief, comfort, and hope. After reading this book, I would know that I wasn't "crazy" or alone. I would find comfort in the fact that researchers were trying to figure out what causes Trichotillomania and were working on finding the best ways to treat it. And, perhaps for the first time, I would have the feeling that I really had a chance to recover.

The book begins by describing Trichotillomania in great detail. To bring a human touch to the specifics of the disorder, Dr. Penzel uses poignant stories from actual Trichotillomania sufferers. The inclusion of these person-

al stories throughout the book is very beneficial and nicely illustrates important points.

After describing Trichotillomania, Dr. Penzel addresses the toll of the disorder and rightfully makes the point that one of its primary consequences is a private feeling of shame, weakness, or isolation. In dealing with these consequences, Dr. Penzel suggests self-acceptance as a central part of therapeutic change. The book is worth buying for this section alone. From there, the book moves into a scientifically informed discussion of Trichotillomania causes. Dr. Penzel provides fair and adequate coverage of all plausible theories, and does an admirable job of discounting baseless theories that may lead persons with Trichotillomania astray while on their path toward recovery.

The crux of the book deals with treatment. Dr. Penzel first describes various therapies and, consistent with available scientific evidence, focuses most of his attention on an enhanced version of a behavioral approach known as habit reversal. After describing the therapy, Dr. Penzel clarifies how the procedure could be done in a self-help format. The self-help chapter is followed by a chapter on medication issues. The discussion on medication is fair, and again, consistent with the available scientific evidence.

The book concludes with four useful chapters on recovery and maintenance, a special chapter for parents who have a child with Trichotillomania, a chapter on how significant others can affect a person's recovery from Trichotillomania, and a chapter detailing available resources for persons with the disorder. All chapters are essential and complement the comprehensive approach to managing Trichotillomania.

In summary, I can see this book being of great interest to a large number of people. Those with Trichotillomania (or family members of someone with the disorder) should read this book because it will allow them to better understand their (or their loved one's) problem, let them know they're not alone, and could aid in their recovery. Clinicians should read it because eventually someone with Trichotillomania will walk through their door and this book will have them prepared. OCD-Spectrum Disorder researchers should read this book because it contains useful summaries of current science and provides a wealth of potential hypotheses worthy of further exploration. And finally, the lay public should read this book if for no other reason than to understand the complexity and diversity of problems with which we as humans struggle and eventually overcome.

*Available through the OCF Bookstore.

Hoarding

(continued from page 1)

* Emotional distress associated with possessions

* Avoidance behaviors designed to limit the experience of distress (see "New Developments" article in the Winter 2003 NEWSLETTER for more extensive discussion)

The next major component of treatment is Exposure and Response Prevention (E&RP). That is, patients gradually expose themselves to the objects or situations that cause them anxiety (having to throw something away, or make a decision about what to do with a specific object). They are then supported as they

resist the urge to respond in their usual way (by keeping something or avoiding making a decision) until the anxiety diminishes. With repeated practice, E&RP will extinguish the fear of losing something important and increase a person's ability to resist the urge to keep things.

Treatment may take place in the patient's home, or, if s/he lives too far away, treatment can just as effectively be carried out in the therapist's office. Before any treatment can begin, the patient must provide baseline photographs of the hoarding area.

When treatment is being carried out in the home, patients are asked to pick one room on which they would most like to work. When they have picked a room, they systematically work their way around the room, discarding and organizing items as they go. They should not move on to another room until the first is completely cleared of clutter. Patients who live too far away to make home-visits feasible and who are, therefore, doing treatment in the therapist's office, will work out a system with the therapist whereby boxes of "clutter" from a specified room at home are brought into the office. Patients often need the help of friends or family members whom they trust to help them with this.

Behavioral treatment for hoarding focuses on four main areas: discarding, organizing, preventing incoming clutter, and introducing alternative behaviors.

DISCARDING

Patients spend a significant amount of treat-

ment time learning how to discard things in an effective manner. Patients go through every single item of clutter and make a decision about its worth before they move on to the next item. There are several ground rules to discarding. The first is that the person must pick up the first item that comes to hand in their pile of clutter. They should not 'sift through' their clutter. Secondly, they must make a decision about that item before they move on to the next item. Patients have three choices when



Kitchen, before

they are making a decision about an item: they can discard it, keep it, or recycle it. Obviously, the preferred option is for the patient to choose to discard the item; and they are actively encouraged to provoke their anxiety by throwing as many items away as possible. Sometimes, patients may decide that they just have to keep an item. They then work with their therapist on where the item will go at home and how it will be organized. Some patients like to recycle things; and this is fine, with the caveat that the recycle options are limited to two places only. Patients may recycle "recyclables," e.g., plastic, paper, etc.; and they may choose one other recycle option, such as, Goodwill or a charity shop. Patients are not permitted to save things for all their friends and family members.

When patients throw something away, they typically become anxious for awhile.

Patients are asked to rate their anxiety (or Subjective Units of Distress – SUDS) and then monitor it as it decreases over time. The anxiety may stay for a few minutes or even a few hours; but it does decrease. It

seems to decrease faster when the patient does not see the discarded item once it is thrown away. The discarding process helps the patient in two ways. First of all, it forces the patient to make decisions, rather than postpone them, and results in a decrease in the anxiety associated with making decisions. Secondly, it helps the patient to see that nothing terrible happens when s/he throws things away that feel valuable. This

directly addresses the patient's obsessive fears of losing valuable or necessary items.

To help patients throw things away, they are prompted to cognitively reframe their obsessive fears about discarding things. They are asked:

* What's the worst thing that would happen if you didn't have this item?

* What do you think other people do with similar items?

* If you needed this information later, how could you access it if you threw this away now?

This process is essential. People who hoard need assistance in learning how to think differently about their possessions. When patients are asked to think about the consequences of throwing away their clutter, they are challenging their erroneous beliefs that dire consequences will occur if they throw something away.

ORGANIZING

Many people with hoarding problems have as much difficulty organizing their stuff as they do discarding it. Frequently, they have piles of stuff on the floor, in walkways, on counters, chairs and tables, all in plain view. Many people dislike putting things away in a cupboard or drawer because they are afraid they will "forget about it." Another problem with organizing is that people with hoarding problems frequently have difficulty with "categorizing." For example, instead of putting a pair of shoes in the closet or on a shoe rack, hoarders want to put one pair of shoes by the front door, "... because I might

wear them next week." Then they want to put other pairs in the den because they need to polish, re-heel or fix them. Other shoes go in a box somewhere because they don't fit right now, but they might later. Thus, the hoarder has difficulty categorizing things in a simple or efficient manner. They



Kitchen, after

tend to "over-categorize" and this leads to confusion and increased clutter. To address this problem, there are several ground rules that must be established (just as for the discarding problem). When patients decide that they have an item that they have to keep, they are asked to immediately identify a specific space at home to put that item and designate a time frame by which it will be done. For example, someone who chooses

Hoarding

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to keep a one-year old bank statement will decide to put it in a manila folder labeled "bank statements" which goes in her desk, in her den. She agrees to do this within two days. The assumption is that if she is not able to do this in the designated time-frame, then the item is not important enough to keep. Patients often need the help of friends or loved ones to make sure that they follow through on daily assignments to put "saved" items away in their designated spaces at home after each session.

Another rule is that once an area is cleared of clutter, it has to be maintained. Patients are encouraged to use the cleared area for its intended purpose. For example, if they have cleared off their couch, they should get used to sitting on the couch during their leisure time. If they have cleared the kitchen counter, they should start preparing food on the counters. Also, patients must empty the trash after every session. They also have a homework assignment to empty the trash at home every day.

PREVENT INCOMING CLUTTER

Clutter should not be coming in as fast as it is going out. Therefore, patients must not only work on discarding and organizing their clutter; but they also have to work on resisting the urge to acquire new items or keep accumulating clutter. Patients are asked to keep a daily log of every item that they have accrued each day. The goal is that the overall number of items accrued each day should decrease. Patients are encouraged to discontinue many of their subscriptions to magazines and newsletters (not the OCD NEWSLETTER, of course!). If a patient has difficulty going into stores without buying things, they receive graduated assignments to go to stores and resist the urge to buy things. They may need to surrender their credit card to a trusted friend or family member until they feel

this compulsion is under better control.

INTRODUCE ALTERNATIVE BEHAVIORS

Hoarding is a full time occupation. It is important to replace hoarding behaviors with more adaptive, healthy behaviors. This is done in several ways. First, although many people with the hoarding problem dislike the idea of schedules, they do, however, benefit from structure in their day.



Living Room, before

Obviously, their participation in this program will mean their days are structured; but when they leave, this structure needs to be maintained. A common problem that these patients have is that they tend to stay up very late at night and then sleep late in the day. It is

important for patients to get back on to a regular sleep/wake cycle. (This may also improve their depression). Another problem is that, with this rather chaotic and unstructured lifestyle, many patients are not taking their medications regularly. With a more structured day, it becomes easier to get into the regular habit of taking medications as prescribed. This too will help with treatment and also improve mood and concentration.

It is important to incorporate recreational time into each day. People with the hoarding problem often report that they never have time to relax or pursue all the hobbies that they express an interest in. They frequently



Living Room, after

by that they stay in bed all the time. So again, patients need help creating balance in each day, a balance of work and recre-

ation and rest. Patients are frequently asked to create a realistic schedule of activities for each day that will include the chores and homework assignments that they have to do, and also a recreational activity and a reasonable time to go to bed.

As part of a structured day, there are several "baseline activities" that patients are required to do on a regular basis. These are activities that many of us routinely do; but for people with hoarding problems, these are often overlooked. Each day patients are asked to empty the trash, do dishes and sort mail. Patients are also encouraged to designate a specific day and time each week to do laundry and pay bills.

Finally, patients need to start working towards more permanent long-term structure. This might mean doing part-time work, volunteer work, or signing up for some classes. Whatever form of structured activity patients choose, they should be assisted in getting it set up and in place before their hoarding treatment program is completed. We do this at our program.

ENDING TREATMENT

It is absolutely essential that patients have follow-up behavior therapy and medication management on at least a weekly basis after they have completed an intensive treatment program for hoarding. We provide for this at the UCLA program. It is not an exaggeration to say that if patients do not follow up with ongoing treatment, they will not maintain the gains they have made in any intensive treatment program.

Because hoarding is such a difficult problem to treat, many patients benefit from doing this type of intensive program a couple of times. At UCLA, a patient's return to the program is contingent on several factors: first, that they are in outpatient therapy; and second, that they have been able to maintain the gains made in the program.

It is highly motivating at the end of treatment to have "after" photos of the area the patient has been working on. When placed next to the "baseline" photos, they enable the patient to really appreciate the progress that s/he has made and provide a visual reminder of the benefit of all his/her hard work.

In conclusion, it would be unfair not to point out that the treatment of compulsive hoarding is extremely difficult. Success will depend on a high degree of motivation and commitment on the part of the patient. However, there is no denying that treatment is also highly effective. The major components of this treatment (education, E&RP, cognitive restructuring) will leave the patient with a set of organizational and decision-making skills that s/he will have forever.

For more information on the UCLA OCD Intensive Treatment Program call (310) 794-7305.

From the President

Dear Friends,

You will notice that in this issue of our newsletter we are running a list of people and organizations who contributed to our recent OCF Research Fund Campaign. Consequently, I thought that I would share with you excerpts of the reports that we recently received from the 2002 OCF



Research Award winners. As you may recall, the Foundation awarded funds for six Research projects in June 2002. At this point, many of them are more than half way to completion. I hope that you will find this research update interesting and informative.

"Cognitive-Behavioral Therapy for Comorbid OCD and Major Depression" – Primary Investigator: Jonathan S. Abramowitz, Ph.D., Mayo Clinic, Mayo Medical School

"The aim of this study," stated Dr. Abramowitz after the 2002 awards were announced, "is to develop effective cognitive-behavioral treatments for the 30% of patients with OCD who also have clinical depression." At the conclusion of the second quarter of the study, Dr. Abramowitz and his colleagues have screened 13 patients and enrolled five in the study. This brings the total number of study participants to six.

"Since there is very little research on the treatment of comorbid OCD and depression (most comorbid patients are excluded from OCD trials)," Dr. Abramowitz explained in his recent report to the Foundation, "we have begun planning on how we will disseminate our preliminary results." They have decided, according to Dr. Abramowitz, to submit a manuscript shortly for publication in a peer-reviewed journal describing the implementation of this treatment protocol in case study format. They also plan to present their preliminary results at the Association for Advancement of Behavior Therapy meeting in November, 2003.

For more information on participating in this study, refer to Dr. Abramowitz's announcement in the Bulletin Board on page 14 of this NEWSLETTER.

"Home-Based versus Office-Based Behavioral treatment of Obsessive Compulsive Disorder" – Primary Investigator: Martin M. Antony, Ph.D.,

Anxiety Treatment and Research Centre, St. Joseph's Hospital

With this study Dr. Antony wants to compare standard office-based exposure and response prevention therapy with home-based E&RP. There is a particular need for doing this research, according to Dr. Antony. "Despite the demonstrated effectiveness of exposure and response prevention therapy for most people with OCD, many individuals receive almost no benefit at all," he explained. "One possible reason for this includes limitations inherent in office-based therapy for OCD. So we wanted to examine this variable."

The hypothesis of this study is that the individuals who receive home-based E&RP will experience greater improvements in their OCD symptoms, lower rates of relapse in the months following treatment and be less likely to drop out of treatment than patients who are treated at the therapist's office.

At this point, according to Dr. Antony, two individuals have already completed the post-assessment and are in follow-up; five more people are currently participating in the protocol. Three others were scheduled to start the program when the report was submitted and four were scheduled for assessment. The investigators put on a public forum on OCD on February 11 and participated in two television interviews to recruit more participants. Anybody with OCD, living within driving distance of St. Joseph's Hospital in Hamilton, ON, and who is interested in participating in this research, should contact Dr. Antony at 905.522.1155, ext. 3048.

"The Effectiveness of Cognitive-Behavioral Treatment for Obsessive-Compulsive Disorder: Do Symptom-Based Subgroups Respond Differently?" – John E. Calamari, Ph.D., Chicago Medical School, Finch University of Health Sciences

"Not all OCD symptoms respond to all treatment equally," noted Dr. Calamari in explaining the purpose of this study. In this study, he wanted to test whether there are significant differences between OCD symptom subgroups and, if so, whether there are significant differences in OCD subgroups' responses to specific treatments. His announced goal at the beginning of the study last June was, "to determine if OCD subgroups respond differently to a standard Cognitive Behavior Therapy protocol."

As of the filing of his progress report, Dr. Calamari along with co-investigator, Dr. Bradley Riemann, has completed pretreat-

ment assessments of 122 people and 99 post-treatment assessments. The investigators working on this project at both Chicago Medical School and Rogers Memorial Hospital have invested a substantial amount of time in entering the data collected and scoring the OC symptoms. The next step is to classify participants by symptom subgroups. When this has been done, the investigators will be able to run the preliminary statistical analyses. They are also continuing to pursue all participants who have reached post-treatment for 3-month, 6-month and 1-year follow-up assessments.

Anyone interested in participating in this research project can contact Dr. Calamari at 847.578.3305 or Dr. Riemann at 800.767.4411, ext. 550.

"Cytochrome p450 2D6 Polymorphisms/Duplications and Serotonin Uptake Inhibitor Response in OCD: A Pilot Study" – Co-Principal Investigators: John L. Black, M.D., and Stefanie A. Schwartz, Ph.D., Mayo Clinic

The question that Drs. Black and Schwartz are trying to answer with this research is whether there is a genetic abnormality that causes rapid metabolism of serotonin reuptake inhibitors (the medication of choice for OCD) and if this is the reason that these medications are ineffective for some people who take them.

In this project the investigators are trying to collect data that will identify the presence of this genetic variation. To date, they have a total of 10 patients who have completed the study, and are now screening others who have expressed interest in the study. The investigators would like to enroll 40 patients in the study. If you would like to learn more about participating in this study, there is an announcement for the study in the Bulletin Board on page 14 of this NEWSLETTER.

"Compulsive Hoarding among Elderly People" – Co-Principal Investigators: Gail Steketee, Ph.D., Boston University, School of Social Work and Randy Frost, Ph.D., Smith College

According to Dr. Steketee, this project "expands a previous investigation of compulsive hoarding among elderly people by employing a standard interview with a larger sample of people over age 60 with and without hoarding problems." At the time they submitted their progress report, the investigators had completed 38 interviews, which included 16 people identified as compulsive hoarders and 23 controls who have minimal or no hoarding prob-

From the President

lems. Besides doing the interviews with each taking between 1 1/2 to 2 hours, the interviewer was able to take photos of some of the homes to demonstrate hoarding tendencies. The referrals for this study have been made by local agencies that deal with the elderly.

"The Effects of Cognitive Behavioral Treatment on Neurochemical Compounds in Patients with OCD: Evaluation of Proton Magnetic Resonance Spectroscopy" – Principal Investigator: Stephen P. Whiteside, Ph.D., Mayo Clinic

The hypothesis behind this study, according to Dr. Whiteside, is that dysfunctions in the cortical-striatal brain circuitry are related to OCD symptoms. The current thought is that abnormal activity in certain areas of the brain, specifically, the orbitofrontal cortex and the head of the caudate nucleus, accompany OCD symptoms. In this study, Dr. Whiteside and his group are using proton magnetic resonance spectroscopy and spectroscopic imaging to determine if treatment with cognitive behavior therapy has any effect on the activities of these two parts of the brain. In explaining his research, Dr. Whiteside stated: "We hope to learn how CBT impacts brain function and how the observed differences in brain function between people with and without OCD are associated with the severity of one's symptoms."

Dr. Whiteside's group has screened numerous volunteers and enrolled four participants who have all received their initial MRS scan. They have also screened four controls; two of whom were accepted into the protocol. If you are interested in participating in this study, please review the announcement in the Bulletin Board on page 14 of this NEWSLETTER.

As you can see, we have some exciting research studies in progress that we hope will yield meaningful results. As we increase our knowledge of how the brain functions with OCD and current and future treatments, we move closer to cures and preventions of this disease.

It is because of you that we are able to support this Research Program. Thank you to everyone who responded to Dr. Jenike's plea and contributed to the OCD Research Fund. Because of your generosity, we are closer to "Effective Treatment for Everyone with OCD."

Best regards,
Janet Emmerman
President
OCF Board of Directors

The 2003 OCF 4th Annual Art Contest and Exhibit*

At the 10th Annual OCF Conference

July 25-27, 2003

Nashville, Tennessee

First Prize: \$1,000.00

Second Prize: \$250.00

Third Prize: \$100.00

If you are interested in mental illness or affected by it, you're eligible to enter and exhibit your artwork in the Contest/Exhibit. We'll accept paintings, collages, photographs, sculpture, fabric work, and drawings.

For more information and an entry form, contact OCF Deputy Director Jeannette Cole at (203) 315-2190, ext. 18, or by email at cole@ocfoundation.org. Application fee is \$10 per entry.

*Sponsored by Patrick Johnson



First Prize 2002



Second Prize 2002



Third Prize 2002

Bulletin Board

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learn about the changes in thinking, memory and emotions that sometimes occur in individuals with Huntington's Disease and Obsessive Compulsive Disorder.

We are seeking men and women (ages 18+) with Obsessive Compulsive Disorder. Each participant in this study will be asked to complete a variety of tasks including paper and pencil tests, computer tests and questionnaires. The project will involve approximately 3 hours of time. Testing will be completed at the Psychology Building at Indiana University, Bloomington, or at the University Medical Hospital in Indianapolis. This will depend on which location is most convenient for each participant. Participants will be paid \$7.00 per hour for taking part in the study, plus a \$4.00 bonus for completing the entire study.

If you would like to learn more about this study, please call 812-856-4511 or toll free at 1-866-786-8849 and ask for Heather Richard or Andrea Solomon. You can also reach us via email at hricha02@indiana.edu

Are You Experiencing: Repetitive Thoughts? Repetitive Senseless Actions? Repeated Washing, Counting or Rituals? Contamination Fears? Hoarding?

You may be eligible to participate in one of the following research studies for individuals with obsessive-compulsive disorder (OCD). Both research studies use magnetic resonance imaging (MRI) to identify brain circuits that may play a role in causing the disorder.

Study 1: Individuals with OCD will receive, a medication approved by the Food and Drug Administration for the treatment of OCD, at no cost to them. To be eligible for this study individuals cannot have ever been treated with any psychiatric medication and must be 18 years or older.

Study 2: This study examines measures of problem-solving and attention for subjects who are already taking medication for their OCD. This study does not provide treatment and participants will be reimbursed for their time and should be 9 years of age or older.

For a free confidential telephone screening to determine eligibility for either study please call (718) or (516) 470-8157. Sessions are scheduled at your convenience. North Shore - Long Island Jewish Health System.

Research: The Hope for Tomorrow

Families with Obsessive Compulsive Disorder are invited to help scientists learn more about the causes of OCD. A team of

scientists at six academic institutions is investigating genetic factors which may increase the susceptibility to OCD. Recent advances in molecular biology and statistical genetics make it possible to identify and describe specific genes that may cause complex diseases, such as, OCD. We are seeking families with OCD to help us conduct these studies.

YOU CAN HELP!

If at least two members of your family are diagnosed with OCD or exhibit symptoms, your family might be eligible for this nationwide study. Participation includes a confidential interview and a blood sample. The interview will be scheduled at a time and place convenient for the participant. Participants will be compensated. Families may be referred by a clinician or may contact us.

To learn more about the study, please contact (collect calls accepted):

- * Rhode Island region
Maria Mancebo (401)-455-6216
mmancebo@butler.org
 - * Boston region
Beth Gershuny (617)-726-7866
bgershuny@partners.org
or Katherine McMullan (617) 726-5594
mcmullan@hmr.mgh.harvard.edu
 - * New York region
Jessica Page (212)-543-6509
 - * Los Angeles region
Melody Keller (310)-825-4132
mkeller@mednet.ucla.edu
 - * Washington DC and nationwide
Diane Kazuba
Local: (301)-496-8977
Toll-free: 1-(866)-644-4363
kazubad@intra.nimh.nih.gov
 - * Maryland and all other regions
Krista Vermillion (410)-575-7326
jacks@jhmi.edu
- The OCD Collaborative Genetics Study includes Brown University, Columbia University, Johns Hopkins University, Massachusetts General Hospital, National Institute of Mental Health and UCLA.

OCD and Depression

The Mayo Clinic OCD/Anxiety Disorders Program is seeking adults with OCD who are also depressed to participate in a treatment study. The purpose of this research is to examine the effectiveness of a comprehensive CBT program that addresses both depressive and OCD symptoms simultaneously. Participants will undergo a 16-session (twice-weekly sessions for 8 weeks) treatment program and receive follow-up assessments. Participants will be partially reimbursed for their participation.

Who is eligible to participate? If you are between the ages of 18 and 70 and suffer from OCD along with depression you may be eligible. You also must be able to attend 16 sessions over 8 weeks at Mayo Clinic in Rochester, MN. Benefits for participants: You may not receive any direct benefits from participating. However, it is possible that your OCD and depressive symptoms may improve from the CBT you'll receive. There is good evidence that CBT is helpful for both OCD and depression. Contact information: The study is being conducted by Jon Abramowitz, Ph.D., and colleagues. Further information is available by contacting Dr. Abramowitz at 507-284-4431, or via e-mail: abramowitz.jonathan@mayo.edu. This study has IRB approval and is being funded by the OC Foundation.

OCD Neuroimaging Study

The Mayo Clinic OCD/Anxiety Disorders Program is seeking adults with OCD for a study on the effects of cognitive-behavior therapy on brain functioning. Eligible participants will receive 16 treatment sessions over 8 weeks (twice-weekly) and have "pictures" of their brain taken with an MRI scan before the first treatment session and following the last (16th session). Participants will also receive compensation for their participation.

Who is eligible to participate? If you are between the ages of 18 and 70 and suffer from OCD you may be eligible. You also must be able to attend 16 sessions over 8 weeks at Mayo Clinic in Rochester, MN.

Benefits for participants: You may not receive any direct benefits from participating. However, it is possible that your OCD and depressive symptoms may improve from the CBT you'll receive. There is good evidence that CBT is helpful for OCD. You can also obtain a "picture" of your brain from the MRI scan.

Further information is available by contacting Dr. Whiteside at 507-284-4431, or via e-mail: whiteside.stephen@mayo.edu. This study has IRB approval and is being funded by the OC Foundation.

Genetics and OCD

The Mayo Clinic OCD/Anxiety Disorders Program is seeking adults who have received successful or unsuccessful medication treatments for OCD. The purpose of this research is to examine the genetics of treatment response to serotonin medication in patients with OCD. It may be possible to use genetic screening to predict who will respond to these kinds of medicines and who will experience side effects or no improvement. Participants will undergo a clinical evaluation, blood draw, and urine screen and be reimbursed for their participation.

Who is eligible to participate? If you are between the ages of 18 and 65 and have received serotonin reuptake medication for OCD (these medications include: Anafranil, Zoloft, Paxil, Celexa, Prozac, Luvox, among others) you may be eligible. Participants must also be able to commute to Mayo Clinic in Rochester, MN.

Bulletin Board

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Further information is available by contacting Dr. Schwartz at 507-284-4431, or via e-mail: schwartz.stefanie@mayo.edu. This study has IRB approval and is funded by the OC Foundation.

University of California Los Angeles (UCLA) is conducting a number of studies on Obsessive Compulsive Disorder. Participants should be able to come to UCLA regularly for appointments.

PET/PAXIL STUDY

This is a 12-week study for people with Obsessive Compulsive Disorder who are not taking medication. This study is researching changes in brain glucose metabolism of people with OCD treated with the medication Paxil. For the participant, this study involves having a PET scan of the brain prior to commencing a 12-week regimen of Paxil and then a second PET scan at the end of the regimen. It also involves having an MRI scan of the brain. Participants will be closely monitored for side effects and efficacy of the medications by their study doctor. For more information on this study please call (310) 794-7305.

PET/PAXIL HOARDING STUDY

This is a 12-week study for people with Obsessive Compulsive Disorder, and more specifically, those people who have the hoarding/packrat/clutter syndrome who are between the ages of 18-65. This study is researching changes in brain glucose metabolism in people with a hoarding problem. For the participant, this study involves a PET scan of the brain prior to commencing a 12-week regimen of Paxil and then a second PET scan at the end of the regimen. It also involves having an MRI scan of the brain. Participants will be closely monitored for side effects and efficacy of the medications by their study doctor. For more information on this study, please call (310) 794-7305.

PET/CBT/NEUROCOGNITIVE TESTING STUDY

This 4-week study for people with Obsessive Compulsive Disorder involves having a PET scan of the brain and a 2-hour battery of neurocognitive tests prior to 4 weeks of intensive Cognitive Behavior Therapy (CBT). Participants will also have an MRI of the brain during the 4 week treatment phase. CBT involves daily (Mon-Fri), 90-minute sessions with a therapist. Participants will receive a second PET scan of the brain and a shortened battery of neurocognitive tests at the end of treatment. This study is looking at changes in brain

metabolism before and after treatment with CBT. It is also looking at changes in neurocognitive functioning before and after treatment. For more information on this study, please call (310) 794-7305.

SEROQUEL AUGMENTATION STUDY

This is a 10-week study for people with Obsessive Compulsive Disorder who have tried standard Serotonin Reuptake Inhibitors (SRI) treatment for their OCD but found little or no relief of their symptoms. The effects of an SRI medication may be enhanced with the addition of Seroquel, an atypical antipsychotic medication. This study is for people who are currently taking an SRI medication for OCD, but find that it is not providing adequate relief of symptoms. For more information on this study, please call (310) 794-1038.

Multi-Center Trial of Ziprasidone (Geodon) Augmentation in Serotonin Reuptake Inhibitor-Resistant Obsessive-Compulsive Disorder (OCD)

The purpose of this research is to obtain data or information on the safety and effectiveness of ziprasidone (Geodon), for the treatment of obsessive-compulsive disorder (OCD) in patients who have not had a satisfactory response to an adequate trial of at least one anti-OCD medication (a serotonin reuptake inhibitor [SRI]). Ziprasidone has been approved by the federal Food and Drug Administration (FDA) as safe and effective for the treatment of schizophrenia. We have decided to do this study because a medication called risperidone, which has actions similar to those of ziprasidone, has been found effective in relieving the symptoms of OCD in patients whose symptoms have not responded to an SRI alone.

Patients eligible to participate in this double-blind study are randomly assigned to receive augmentation of their SRI treatment with either ziprasidone or placebo (an inactive substance that provides no medical treatment) for 8 weeks. There will be a maximum of 8 visits in total. Each visit should last about an hour, except for the pre-study and final visits, which will last approximately 4 hours and will involve the following procedures: an extended interview by a psychiatrist to document your symptoms (every visit), a complete physical examination by a doctor of internal medicine, an EKG, and a blood sample will be drawn.

To be eligible, patients must be between the ages of 18 and 65, have OCD as their primary diagnosis, have obtained an unsatisfactory or no response from at least one, and up to three adequate SRI trials (Serotonin Reuptake Inhibitors: Anafranil, Effexor, Celexa, Luvox, Paxil,

Prozac, and Zoloft), and agree to continue on their current SRI medication. Additional eligibility requirements will be reviewed with each patient during a detailed phone screening. For more information, please contact: Helen Chuong, Clinical Research Coordinator (650) 498-5644, email: helenc@stanford.edu or visit our web site: <http://ocd.stanford.edu> Stanford University Medical Center Department of Psychiatry/OCD 401 Quarry Rd. Stanford, CA 94305-5721

Still Having Obsessions or Compulsions? Not Satisfied with Your Medication?

The University of Florida Department of Psychiatry is conducting a study on adding a research medication to certain medications used for treating Obsessive-Compulsive Disorder (OCD), such as, Prozac, Paxil, Zoloft, Celexa, or Luvox.

To be eligible, you must be 18 to 65 years old and in general good health. The study includes: office visits, medical exams, laboratory tests, psychiatric evaluations, and study medication. If interested, please call our referral line toll-free at 877-788-3994 or e-mail us at clintrls@psych.med.ufl.edu

The New York State Psychiatric Institute Seeks Participants for Magnetic Resonance Imaging Study

This 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 various neuropsychological assessments. By comparing the MRI data from individuals with disorders to that from healthy control subjects, the study will help further our understanding of the neurological basis behind disorders such as OCD.

Who is Eligible?

Individuals with OCD, Tourette's and/or ADHD as well as healthy controls between the ages of 6 and 65 are eligible. Payment: Participants will be compensated \$80 for their time. Contact: Victoria Stein

The New York State Psychiatric Institute
Unit 74, Rm 2301
1051 Riverside Drive
New York, NY 10032
(212) 543-6287

steinv@child.cpmc.columbia.edu

Note: The study will be conducted at the Yale Child Study Center in New Haven, CT, not at NYSPI.



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