

RETHINKING THE UNTHINKABLE

Steven Phillipson, Ph.D.
Clinical Director
Center For Cognitive-Behavioral
Psychotherapy
New York, New York

The following is an update of an article that was originally published in the OCD Newsletter in 1991. Back then, behaviorists were still telling people with the Pure-O form of OCD (where the sufferer experiences obsessions only) that they hoped medication would be of some benefit. To their knowledge, there were no known methods of treatment that reliably produced positive outcomes with this form of OCD. In 1987, I had developed a highly structured and formalized behavioral method of treating this form of OCD. These treatment guidelines were derived from current strategies, proposed by Dr. Edna Foa, for the treatment of the more traditional forms of OCD (e.g., contamination and checking). Specifically, the strategy called Exposure and Response Prevention (E&RP) entails the practice of having the patient voluntarily come in contact with the feared items or situations, and then manage the pursuing anxiety while not performing the undoing response. The adaptation of E&RP for Pure-O required a few modifications, but essentially retained the same empirically-based treatment model. Initially, the duration of treatment for the Pure-O was significantly longer (two years) than the duration of the tradi-

tional treatment of OCD (six months to one year). Using the adaptation model of treating the Pure-O form, the success rate that was achieved was in the 70% to 90% range. This was comparable to Dr. Foa's findings. In the mid-1990's, Mark Freeston, Ph.D., published one of the first controlled studies for the treatment of Pure-O, using very similar methods to those proposed by my 1991 article. His methodology relied on a much stronger cognitive component than my approach, which, as discussed below, has retained a much stronger behavioral component. Cognitive treatment for anxiety disorders relies on helping people identify the irrational nature of their fears and find the evidence of their irrationality. My work with thousands of patients has lent strong support to the idea that the cognitive element is not nearly as important as the more strict behavioral element, which focuses on providing effective strategies for managing the threatening ideas, rather than debunking the specific irrationality of the idea. At this point (2004), I am finding that, with some slight innovations that I have laid out below, there are no differences in the treatment duration (approximately six to twelve months) for people with Pure-O and those with the compulsions of the more traditional form of OCD.

In my conceptualization of Obsessive Compulsive Disorder, the tree of the overall syndrome has three main branches: the obsessive-compulsive, the responsibility O-C, and the purely obsessional thinker

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New Officers Elected to OCF Board of Directors

At their Annual Meeting on February 28, 2004, in Hartford, Conn, the directors of the Obsessive Compulsive Foundation elected officers for a term of two years. The new officers chosen by the board are: President – Joy Kant of Newton, MA; Vice President – Thomas Lamberti, Garden City, NY; Secretary – Christina Vertullo, Staatsburg, NY; and Treasurer – T. Carter Waddell, Alpharetta, GA. Mrs. Kant has been a member of the OCF Board of Directors for three years and its treasurer for two years. She is also the owner of Joy Kant Fine Art in Newton, Mass. In discussing her goals for the Foundation, she said, "The Foundation's core concern is finding and providing effective treatment for everyone with OCD. While I am president, I am going to actively work with people in government, in the medical community and in the private sector to support that core concern. I want to make the OC Foundation a very inclusive group that will have the resources and the people to develop effective treatments for everyone with OCD."

The Foundation's recently elected vice president, Thomas Lamberti, is a partner at the New York City law firm of Putney, Twombly, Hall and Hirson, LLP. He has been a board member for three years. Christina Vertullo, who is an Instructor in Mathematics at Marist College and co-facilitator of the Hudson Valley OCD Support Group in Poughkeepsie, NY, was re-elected to her third term as secretary. Ms. Vertullo has been on the OCF Board of Directors since 1999.

Mr. Waddell was chosen to serve as the Foundation's treasurer. He is a senior officer in the International Division of SunTrust Bank in Atlanta, GA, and has been an OCF director since 1999.

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From The Foundation

Dear Friends,

The investigators in the OCF Genetics Collaborative are searching for the gene or genes that cause OCD and they need your help. First, they need you and your family to volunteer to participate in the family studies that are being conducted at: Brown University, Columbia University, Johns Hopkins University, Massachusetts General Hospital, the National Institute of Mental Health, the University of California at Los Angeles and University of California at San Diego.

The OCF Genetics Collaborative (OCFGC) is an international group of investigators, brought together by the OC Foundation, who are working collaboratively to identify the genetic causes of OCD. They are investigating the genetic causes of OCD in order to understand how OCD develops. They have to learn how OCD develops in order to find ways to prevent it and to treat it more effectively.

They cannot carry out their research without your help and support. First, they need individuals with OCD and their families to take

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BULLETIN BOARD

TRAINING WORKSHOP FOR PROFESSIONALS AT THE CAPE COD INSTITUTE, JULY 12-16, 2004

Cognitive-Behavioral Therapy for OCD and Anxiety: Effective and User-Friendly Treatment for Children and Adolescents

Aureen Pinto Wagner, Ph.D., will be presenting a five-day intensive workshop that is designed to provide mental health and school professionals with in-depth training and consultation in the application of CBT for OCD and other anxiety disorders. Participants will develop creative and individualized treatment plans through lecture, clinical vignettes, and group discussion in an open clinical forum. Strategies for developing treatment-readiness, collaborating with families and schools, working with reluctant children, relapse prevention, and managing challenges in treatment will be discussed.

For more information or to register, please visit www.Cape.org or call 888-394-9293 (toll-free) or 203-422-0535 or email: pro-learning@behavior.net

PANIC DISORDER AND SOCIAL ANXIETY DISORDER: DO GENES MATTER?

Are you interested in participating in a study of a new approach to understanding the genetic contribution to panic disorder and social anxiety disorder? For the last three years or more, Nobel Laureate and neuroscientist, Eric Kandel; psychiatrist Abby Fyer and I, Miriam Weissman, Ph.D., have been meeting to develop novel approaches to understanding the genetic contribution to anxiety disorders, particularly, panic disorder and social anxiety disorder (social phobia). Dr. Kandel had been studying the neurocircuitries of fear responses in animals and reasoned that there were similarities in fear conditioning circuits in animal models and in humans. The same genes involved in the animal models may guide understanding of human anxiety disorders. Anxiety disorders represent a malfunction in the neural mechanisms that detect danger and mobilize adaptive responses to that danger and that these neural mechanisms are determined by subsets of genes that may make individuals more or less susceptible to fear responses and to anxiety disorders.

It took us some time to decide which of the human anxiety disorders would be most tractable to study genetically. We finally decided to concentrate on panic disorder and social anxiety disorder. We

were interested in panic disorder because the symptoms are very easily recognized. The onset is in early adulthood and is impairing. The disorder occurs across diverse countries. Studies of first-degree relatives have shown that it is highly familial, with over an eight-fold risk of panic disorder in the first-degree relatives i.e., the parents or children of patients with panic disorder. Twin studies have suggested a heritability of about 45%, which is similar to the heritability of other disorders of complex genetic etiology.

We also chose phobias. While phobias are clinically heterogeneous with a common feature of avoidance behavior, secondary to irrational fears of objects, activities or situations, there are many different types of phobias. The most consistent information was on social anxiety disorder (social phobia). Patients with social anxiety disorder are highly impaired and they are likely to develop other anxiety disorders and to abuse alcohol or other substances, probably as self-medication. Social anxiety disorder also has been identified across diverse cultures. Like panic disorder, it begins early, often in the teen years and only about 25% of patients ever seek treatment because patients think the anxiety symptoms are part of their character and not treatable. Studies of first-degree relatives have shown over a five-fold increased risk in first-degree relatives of patients with social anxiety disorder.

Other anxiety disorders, such as, PTSD, generalized anxiety disorder, or obsessive-compulsive disorder, would have been interesting to study, but there was less information available on them. We decided to begin with these two anxiety disorders. We are now seeking 800 persons with either panic disorder or social anxiety disorder to participate in the study.

What is panic disorder? Panic disorder consists of repeated, sudden episodes or "attacks" of intense or extreme fear and physical symptoms, which may include:

- chest pains or heart palpitations
- difficulty breathing or choking
- dizziness

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Obsessive Compulsive Foundation, Inc.

Phone: (203) 401-2070

Fax: (203) 401-2076

e-mail: info@ocfoundation.org

www.ocfoundation.org

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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.

How I Treat OCD

In this feature, prominent clinicians who treat OCD will explain some of their theories and techniques. The NEWSLETTER'S goal is to disseminate information about different treatments and to open a dialogue among practitioners and researchers on the best ways to treat OCD. We invite our readers to submit articles describing the way they treat OCD.

Treatment Themes

Stephen C. Josephson, Ph.D.



There are a number of themes that distinguish my way of working with individuals with OCD. In no particular order, they are:

1. Readiness for change. Many behavior therapists, in my experience,

jump in with action-oriented suggestions and pay insufficient attention to an individual's receptivity to those directives. Many individuals doubt the value and benefits of changing as well as being concerned about the discomfort involved. It is often most helpful to educate the person extensively about his/her illness including its biological origins. This can reduce self-blame and set the stage for the OCD sufferer assuming responsibility and taking a more active role in treatment. Sufferers can also benefit from reading the research literature to accurately assess the statistics regarding success vs. the anticipated negative effects. I have also found that it can be valuable to have patients who are unwilling to commit to exposure treatment speak anonymously to previously treated patients. Change and progress in therapy are dynamic processes and each session requires fine-tuning based upon patient receptivity.

2. Comorbidity. In my clinical experience "nature is generous" and most OCD sufferers have a cluster of other symptoms. For instance, many individuals with OCD have some comorbid ADD spectrum symptoms. These include problems with organization, procrastination, task completion, time management and, often, impulsivity. I look for: (1) academic difficulties (2) clutter and indecision, and/or (3) impulse disorders (e.g. addiction, hair pulling, interest in pornography, propensity for reckless driving). Unfortunately, most ADD sufferers need specific medication to be able to adequately and consistently complete behavioral assignments. Similarly, depression interferes with exposure-generated habituation and contributes to noncompliance in light of the effort that exposure therapy requires. Treatments for depression include activity scheduling, cognitive restructuring, physical exercise, assertiveness training and medication.

Last but not least, I try to assess and treat undervalued and fixed ideas using socratic CBT as opposed to RET (rational emotive therapy) confrontation. Direct confrontation has been shown to lead to greater conviction and a breach in the therapeutic alliance. With this subset of people, neuroleptic medication may be invaluable prior to doing exposure.

3. Cognitive Compulsions.

Developmentally, there is a shift from behavioral to mental rituals as we age; and unless one clearly distinguishes between obsessions vs. compulsions, it is unclear whether to expose or advise response prevention. Remember the functional rule of thumb, i.e., obsessions increase distress; compulsions are designed to reduce dysphoric mood and negative outcomes. Teach mindfulness meditation and mental response prevention. Patients need to be prepared for intrusive thoughts by acknowledging their presence, interrupting the chain and returning to a nonverbal sense of presence. This amalgam of Eastern religion and "brain lock" is finally being explored. Use metaphors and language which are consistent with the patient's world view.

4. Significant Others. Whenever possible include family members in the treatment to create more social support. In addition, significant others often need help in withholding reassurance and that system needs to be reconfigured with the presence and consent of the patient.

5. Optimism. Both clinicians and patients need to be prepared for a long, drawn-out war with OCD. A strong therapeutic relationship based upon trust and a shared perspective on the illness is crucial. Similarly, there needs to be agreed upon treatment expectations and roles. Optimism is an attributional style variable that has been carefully researched and is important to consider in this process. Because self-directed therapy requires tremendous perseverance, it is common for patients to develop pessimistic attitudes that place them at heightened risk for depression. Optimists deal with negative life events very differently than pessimists. Optimists tend to see negative life experiences as specific events that are transient in their effects and therefore modifiable. They also do not blame themselves for these negative life events but are willing to accept responsibility when appropriate. Because research on pessimism indicates that giving up and becoming depressed is

a common response to negative life events, it is crucial that we try to help our patients be optimistic in order to continue to fight the OCD. "Optimism training" is not the same as misused cognitive interventions, such as, reassurance which becomes just another ritual very quickly. Cognitive therapy is best applied to the need to take risks and perfectionism. Ultimately, we all need to tolerate the possibility of negative outcomes including making a mistake.

6. Home visits can be extremely helpful. It directly reflects your commitment to your patient's improvement and often allows you to see and accomplish more in a home visit than you can in months in the office. However, it is important that you respect how vulnerable your patient has made himself by allowing you into his home. You need to make a conscious effort to recognize openly that you are a visitor and the OCD sufferer still retains ultimate control over what you do and don't do in his/her home.

7. Medication. Active collaboration with a psychopharmacologist is crucial. It is important to be assertive with them and encourage psychopharmacologists not to accept suboptimal outcomes. Honest expectations regarding medication transitions and side effects are very important.

8. Other factors. I have moved away from long obsessive hierarchies to short duration E&RP assignments with extensive debriefing in order to maximize learning. OCD treatment is not just about deconditioning, but is also about learning the most from every therapy experience. A personalized approach to OCD focuses on sustaining motivation so that sufferers continue to confront their fears for the rest of their lives. Ancillary support systems such as GOAL groups can be extremely helpful in this regard. I also believe in exploring and exploiting a patient's areas of strength and interest (e.g., athletics) and helping sufferers see ways of applying successful strategies to their OCD. Finally, with children it is key that you build their confidence and use a lot of external reinforcement as well as giving them control over the actual content of the treatment. Last but not least, it is crucial that we not give up on patients if they are going through a difficult time and remember that we are treating people not diagnoses.

Dr. Josephson practices in New York City and can be reached by calling 212-288-2777.

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(Pure-O). In Pure-O, the anxiety emerges in response to an unwanted, intrusive thought or question; what I call a "spike." The ritual or compulsion with this form of OCD involves the non-observable, mental "pushing away" of the thought, avoiding the recurrence of the thought, or attempting to solve the question or undo the threat that the thought presents. It should be remembered that most people who come into therapy tend to have a combination of these three distinct forms of OCD. Successfully treating one form typically has minimal effect on the others. When persons present with more than one form of OCD, treatment will tend to initially focus on the observable rituals, because they are generally easier to treat and provide a positive momentum for further therapeutic work.

Pure-O has two parts: the originating unwanted thought (spike) and the mental activity in which the sufferer attempts to escape, solve, or undo the spike. This is called "rumination." With Pure-O, it is the threatening, nagging, or haunting nature of the idea, which compels the patient to engage in an extensive effort to escape from the thought. Most likely, it is not the intrusive idea *per se* that drives the response, but the associated emotional terror. The following are some illustrations of these types of Pure-O situations.

1. A man is involved in sexual relations with his female lover. Just prior to orgasm, the thought of his friend Bob pops into his head. This is the fourth time in a month that this has happened. In response to this, he becomes very upset and wonders whether or not he is gay. His sexual activity is terminated in order to avoid having to deal with this concern.
2. A mother is changing the diaper of her infant. As she lovingly looks down at this helpless child, the thought occurs to her to "take a pillow and smother him." In response to this thought, the mother panics and runs to another room to diminish the possibility of acting on this thought, because she feels that having the thought is tantamount to acting on it.
3. A student finishes a conversation with his favorite professor. For the next three hours, the student reviews the conversation mentally to ascertain if he said anything that might have been offensive.
4. An altar boy in church notices a statue of the Virgin Mary. He has a fleeting thought about performing a sexual act on her. He is tormented endlessly, even though he has repeatedly confessed the thought to a priest and to his parents.

5. A young man notices that the word "suicide" is repugnant to him. It is not that he is depressed; he feels that the word "suicide" "shouldn't" stand out. He finds that, not only does encountering the word in print produce a tremendous amount of emotional tumult, but hearing it in his own thoughts becomes equally upsetting. Certain sounds also start to stand out as being unique and unsettling. He begins to spend a great deal of time wrapped up in his own thoughts, attempting to arrange the word in a certain manner so that it possesses less significance. He becomes tormented by the possibility that the unique sounds surrounding him may linger on for eternity and determines that he must find some method to stop being reminded of their occurrence.

6. A woman survives emotional abuse from an overly controlling father. At 20, she leaves his house and she's elated. However, she develops an obsession. She decides that all objects, which remind her of him, are infused with his essence and, therefore, must be discarded. Although irrational, she feels that discarding anything related to him will keep her identity free from his influence. She feels that to completely free herself from him, she has to discard all objects that remind her of her father, even those that might have been "contaminated" by contact with his possessions. This effort to free herself from her father's influence becomes so encompassing that she has to avoid even mail from her siblings because her father might have come in contact with something that might have come in contact with the mail.

For the person suffering with Pure-O, a tremendous amount of anxiety and/or guilt accompanies the spike. The mental ritual (rumination) is the volitional effort to shut off the anxiety, either by attempting to gain reassurance, solve the question, or avoid having the thought recur. The tormenting thought (spike) typically entails two parts. The first is the idea that the thought, in and of itself, is deviant and signifies something horrible about the person who has it. "I must be a sick, mentally unstable person to have had this thought." The second part is the great emotional and physical discomfort accompanying the intrusive idea. The symptoms of anxiety can include, but are not limited to: rapid and heavy heartbeat, upset stomach, excessive perspiration, muscle fatigue, mental thoughts and/or muscular tension. These symptoms are what make people with OCD "feel" that the spike is so problematic. It is during the rumination phase that the person's mind becomes extremely

preoccupied and distracted. It is not unusual for someone with Pure-O to spend endless hours trying to "escape" from these thoughts. The need to stop these thoughts is tremendous. A common misconception among Pure-O sufferers is that there is a way to turn off the obsession, and that they just have to keep obsessing until they hit upon that way. If they can find "the answer," the right thought, then the obsessing will just vanish completely. Most sufferers realize this is impossible, but they cannot give up the search.

The diagram on pages 8 & 9 illustrates the endless cycle of spiking and ruminating. On the left-hand side of the diagram, you will see references to Subconscious Mental Processes and the Anxiety Center. The Subconscious Mental Processes are located in the outer portion of the brain and represent parts of the brain that are creative and always on the lookout for pertinent information. Evidence of their existence lies in a phenomenon known as the "Tip-of-the-Tongue" effect (Brown & McNeil, 1966). All of us have had the experience of searching for a word or fact that is just on the tip of our tongue, but continues to elude us. Eventually, we give up trying to recall it and go about our business. Then, later, it pops into our consciousness, even though our mind is preoccupied with another topic. I believe that there is a non-conscious portion of the brain that searches for meaningful material and sends this information to one's consciousness. One tends to more readily notice information that has a strong association component with significant material than non-relevant information. For example, when we see a red light, we immediately react to it as a warning (i.e., unconsciously, we associate a red light with the idea of a hazard). For the Pure-O sufferer plagued with thoughts of violence, the sight of a knife might spike the thought of stabbing a loved one. The Anxiety Center (left side of the diagram) is closely associated with the Subconscious Mental Processes (see diagram). This portion of the brain is called the amygdala. Brain mapping studies suggest that the amygdala is responsible for people feeling great emotional upheaval. On occasion, the amygdala is triggered by external stimuli. One example of this would be finding a snake in your tent.

In the case of panic attacks, seemingly spontaneous and random events can trigger the amygdala to misfire and send the same types of signals. The Anxiety Center is responsible for the fight-or-flight response. Brain-mapping studies suggest

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that the amygdala, or brain stem, is the center of visceral awareness that there is an urgent threat demanding immediate attention. The Anxiety Center activates responses to emotional information, such as, rapid heart rate, racing thoughts or upset stomach. The Resource Center transmits information to our conscious awareness that deems material relevant or significant. It is at this juncture that most Pure-O's becomes fixated and distraught.

The transmission of the information from these Subconscious Processes to our Conscious Awareness is a purely reflexive one and completely beyond our control. However, it is not beyond our influence. When the spike reaches our Conscious Awareness, we have a choice as to how to process the thought (represented by the two arrows in the diagram on pages 8 and 9). The arrow pointing upward suggests that the person experiencing the stimulus chooses to believe that the spike thought represents or reflects something deep and meaningful about the person; e.g., "only a vicious, loathsome human being could possibly think of stabbing their loved one." This is referred to as the Instinctive Response because it is inherent within each person to resist anything which feels so threatening. People with OCD are not less tolerant of these upsetting ideas, which most humans report are a natural part of their daily existence. It is just that people with OCD experience a "misfire" in the brain that makes them "feel" as if the idea is problematic. Usually, an effort is made to seek reassurance and disqualify the legitimacy of these upsetting ideas and threatening experiences.

The Instinctive Responses naturally produce the strong desire to engage in resistance and relief seeking. This represents, as Albert Ellis (1987, 1991) has suggested, a dysfunctional emotional response. The tremendous effort one puts into escaping the unwanted thoughts or preventing their recurrence (e.g., hiding knives), in effect reinforces (e.g., strengthens the association) their importance to the non-conscious brain and thereby feeds the vicious cycle. This process is represented in the accompanying diagram by the arrow pointing from the top box back toward the Anxiety Center. Similar notions have been proposed by Wenzlaff, Wegner, & Roper (1988). These authors suggest that attempting to suppress thoughts has the effect of making them stronger. Recognizing that you are upset by a thought and then reacting with resistance places a mental marker on it and increases the likelihood of the thought reoccurring. For the sufferer with Pure-O, the spike is a double-barrelled shot of anxiety. First, there is anxiety for having such an unpleasant or deviant thought. Then, the tremendous, uncon-

trollable repetitiousness of the thoughts makes the sufferer think he is losing his mind. The uncertainty regarding mental loss of control can be a very anxiety-provoking experience.

According to the Conscious Awareness box in the diagram, the arrows pointing downward represent the least likely response, but, ultimately, the most therapeutic one. The "Extinction Response" entails recognizing the existence of the "bad" thought, but assigns no blame to the person for having it. This response allows the upsetting ideas to exist, despite the presence of the accompanying extreme anxiety. Many cognitive-behavioral psychologists believe that the absence of this response is what distinguishes people with OCD from the "normal" population. In contrast, the cognitive psychologist believes that just by shedding light on either the irrationality of the idea of being a bad person or on the fact that the thinker is not responsible for the initiation of the thought, relief from anxiety will result. However, those with OCD would suggest that in order for psychologists to fully understand what they are experiencing, the psychologists' amygdalas should be stimulated to the point of feeling like the world is ending. The experience of feeling compelled to then "run for the hills" would be shared. The Extinction Response is not the reflexive one, nor does it occur naturally when feeling so unsettled. In fact, the Extinction Response feels so unnatural because it is diametrically opposed to what we are evolutionarily wired to do when faced with anxiety. Therefore, it is crucial for the patient to understand that OCD involves a faulty wiring, not an irrational belief system.

For a behavioral psychologist, the key issue is not how or why these thoughts become out of control, but what to do about them when they're racing around in one's head eight hours a day. It is extremely distressing that this form of OCD continues to present such confusion for mental health professionals. There remains a good deal of ignorance regarding appropriate treatment strategies and conceptualizations. Today the most common trend for cognitive-behavioral psychologists is the use of "rational responding" as a means of managing Pure-O. Although people with OCD "feel" as if the obsessive thought is legitimate, they typically remain steadfastly aware that they are performing extensive or elaborate escape responses for no logical reason. Clearly, it does not make sense that the therapeutic objective should be to help the patient "find the evidence" that the thought is illegitimate. But before discussing what works, it is critical to discuss what does not work!

Thought stopping, both through shouting, "STOP" or snapping a rubber band in response to the spike, is clearly not recommended and may actually be detrimental. As discussed previously, this technique sensitizes the brain to the unwanted thought by alerting the Anxiety Center that potential punishment is associated with the spike. Theoretically, the spikes would thus increase due to this heightened sensitivity. Research to date has demonstrated that these techniques are not effective treatments for OCD.

Although logically pointing out the absurdity of the Pure-O patient's mental rituals is very tempting, it is often insulting and clearly ineffective. You cannot "outlogic" OCD. People with OCD are understandably drawn to this type of therapy because the therapist is actually reassuring the patient by helping the desperately anxious patient see the irrational nature of these threatening ideas. This type of treatment ultimately can make the patient dependent on the therapist's determinations of what is rational and what is not, and is, therefore, an ineffective treatment approach.

Another treatment approach involves the use of analytic interpretations. This approach assigns meaning and significance to the content of the spike and attempts to instruct the patient to "understand" this meaning. This understanding or insight supposedly is both necessary and sufficient to produce change. However, we now believe that this approach for OCD is not only ineffective, but actually is detrimental and may further fuel and reinforce the OCD process. Nevertheless, many people with untreated Pure-O are unfortunately still drawn to this type of therapy approach because they have a natural inclination to investigate, make meaning of their spikes, and find solutions to their upsetting thoughts. The process of trying to find solutions to alleviate the anxiety and upset is referred to as rumination and is clearly part of the maladaptive management of the disorder. Initially, when an OCD patient begins behavior therapy after years of analytic or insight therapy, he needs to be deprogrammed. Only then can the full benefit of behavior therapy be achieved.

In 2004, while there is a great deal of scientific evidence that thought stopping, rubber band therapy, and analytical therapy are not recommended and are ineffective for treating OCD, many psychologists are debating whether or not there is any benefit to using cognitive strategies as an additional component to behavior therapy. The idea behind fundamental behaviorism is to change brain chemistry through conditioning. The underlying belief is that patients with anxiety disorders do not have defects in their thinking processes.

Research Digest

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

The following is a selection of the latest research articles on OCD and related disorders in current scientific journals.

Do patients with obsessive-compulsive disorder have deficits in decision-making?

Cognitive Therapy and Research, 27:431-445, 2003, E.B. Foa, A. Mathews, J.S. Abramowitz et al.

Difficulty making decisions related to obsessional concerns and rituals is a common problem for individuals with OCD. These researchers examined three aspects of decision-making in OCD: (1) the amount of information requested before making a decision, (2) the amount of time spent deliberating before making a decision, and (3) the level of risk the decision carried. Eighteen individuals with OCD and 18 nonanxious controls were presented with 12 scenarios in which they had to choose between two alternatives. Scenarios had varying degrees of risk: low risk (such as selecting a brand of car wax); high risk (such as selecting between two treatments for an injured relative); and risks related to fears common in OCD (such as selecting the safest gas stove). In making high-risk decisions, individuals with OCD did not differ from controls in the amount of information requested to make the decision or in the amount of time spent making the decision. However, significant differences were found for the low risk and OCD-relevant decisions: individuals with OCD requested more information and spent more time making decisions.

A double-blind switch study of paroxetine and venlafaxine in obsessive-compulsive disorder

Journal of Clinical Psychiatry, 65:37-43, 2004, D. Denys, H.J.G.M. van Meegen, N. van der Wee et al.

Current guidelines for medication treatment of OCD propose trying a second serotonin reuptake inhibitor (SRI) if the first one doesn't work. Although recommended, this strategy has not been well researched. In this double-blind switch study, 150 patients with OCD were randomly assigned to a 12-week trial of venlafaxine (Effexor) or paroxetine (Paxil). Nonresponders, after a 4-week tapering off the first medication, were

switched to 12 additional weeks of the alternate SRI. After the medication switch, 42% of the nonresponders benefited from the second SRI. Paroxetine was more effective than venlafaxine in the treatment of nonresponders to the first SRI trial. In combining data from both first and second trials, 67% of the patients responded to paroxetine whereas 44% responded to venlafaxine. Venlafaxine is a serotonin-norepinephrine reuptake inhibitor (SNRI) and has demonstrated effectiveness in OCD. Finding venlafaxine to be less effective than paroxetine, this study does not support its use as a first- or second-line treatment. This study does support trying a second SRI if the individual does not respond to the first SRI tried.

Platelet serotonergic predictors of clinical improvement in obsessive compulsive disorder

Journal of Clinical Psychopharmacology, 24:18-23, 2004, R. Delorme, N. Chabane, J. Callebert et al.

Serotonin reuptake inhibitors (SRIs) are the most effective medications used in the treatment of OCD. Unfortunately, not everyone responds to SRI medications and it would be useful to find physical measures to distinguish responders from nonresponders before treatment. These researchers tried to identify peripheral serotonergic measures that could help predict response to SRI treatment. They compared 19 OCD patients before and after 8 weeks of SRI treatment with 19 non-OCD controls. Clinical improvement was compared to whole-blood serotonin levels, platelet levels of serotonin transporter and inositol triphosphate (IP3), and serotonin receptor binding characteristics. Before treatment, OCD patients had higher platelet IP3 content and fewer serotonin transporter binding sites than the controls. Treatment with SRIs further lowered the number of binding sites, normalized platelet IP3 contents, and lowered the whole-blood serotonin concentrations below control values. The patients who improved most with SRI treatment had higher whole-blood serotonin concentrations before treatment. This study supports the relationship between serotonin and OCD. It also suggests that high blood levels of serotonin may be useful in predicting who will respond to SRI medications.

A placebo-controlled trial of bupropion SR as an antidote for selective serotonin reuptake inhibitor-induced sexual dysfunction

Journal of Clinical Psychiatry, 65:62-67, 2004, A.H. Clayton, J.K. Warnock, S.G. Kornstein et al.

Selective serotonin reuptake inhibitors (SSRIs), medications used to treat both OCD and depression, may impair sexual functioning. This double-blind study compared sustained release bupropion (Wellbutrin SR) as an antidote for sexual dysfunction to placebo in 42 patients with SSRI-induced sexual dysfunction. Treated for depression, all patients had been taking SSRIs for at least 3 months before beginning the study. Sexual function was evaluated after 4 weeks of the combined treatment (SSRI plus bupropion versus SSRI plus placebo). Bupropion increased the desire to engage in sexual activity and the frequency of engaging in sexual activity. Improvement over placebo was not found for sexual interest, arousal or orgasm. Researchers conclude that improvements in sexual function when bupropion is added to an SSRI may improve quality of life and medication compliance in patients with SSRI-induced sexual dysfunction.

Impact of age at onset and duration of illness on the expression of comorbidities in obsessive-compulsive disorder

Journal of Clinical Psychiatry, 65:22-27, 2004, J.B. Diniz, M.C. Rosario-Campos, R.G. Shavitt et al.

Frequently patients with OCD suffer from comorbid (additional) psychiatric disorders. In this study, 89% of the 161 outpatients with OCD had at least one comorbid diagnosis, a high incidence that is similar to findings in other studies. Researchers explored how the age at onset of OC symptoms would affect the presence of these comorbid disorders, taking into account the effects of the length of time patients had suffered with OCD. An earlier age at onset of OCD was associated with comorbid tic disorders, eating disorders, kleptomania, trichotillomania and bipolar disorder. A longer illness duration was associated with comorbid depression. The presence of social anxiety disorder was associated with both early onset and longer illness duration.

Research Digest

Cognitive-behavioral family treatment of childhood obsessive-compulsive disorder: a controlled trial

Journal of the American Academy of Child and Adolescent Psychiatry, 43:46-62, 2004, P. Barrett, L. Healy-Farrell and J.S. March

This study compared the effectiveness of individual cognitive-behavioral family-based therapy (CBFT) to group CBFT. Conducted at a university clinic in Australia, 77 children and adolescents with OCD were randomized to individual CBFT, group CBFT or to a wait-list control condition (no CBFT). Both individual and group CBFT produced significant reductions in OCD symptoms in contrast to the wait-list control condition. Significant improvements occurred as early as week 6 of CBFT and continued across time to week 11. Additionally, improvements were maintained up to 6 months post-treatment. Similar to other studies, these results demonstrate that cognitive-behavioral therapy is effective in reducing OCD in children and adolescents. Contrary to their expectations, group CBFT was as effective in reducing OCD symptoms as individual CBFT.

Detecting pediatric autoimmune neuropsychiatric disorders associated with streptococcus in children with obsessive-compulsive disorder and tics

Biological Psychiatry, 55:61-68, 2004, T.K. Murphy, M. Sajid, O. Soto et al.

In a subgroup of children, streptococcal infections have triggered the onset or worsening of OCD and tic disorders. This is referred to as PANDAS (pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections). This study investigated the relationship between streptococcal infections and OCD symptom fluctuations in 25 children with OCD and/or tic disorders. Illness severity and group A streptococcal antibody titers (streptolysin O, deoxyribonuclease B and carbohydrate A) were measured at 6-week intervals for six or more evaluations. Children with large symptom fluctuations (n = 15) were compared to children without dramatic fluctuations (n = 10). Children with marked OCD/tic symptom changes were more likely to have elevated antibody titers. Additionally, children with elevated antibody titers had tic symptom worsening occur more often in the fall/winter months than spring/summer months.

How We Treat OCD

Family Culture Matters

Lee Fitzgibbons, Ph.D.
Gordon Street, Ph.D.



In our work, we have noticed on numerous occasions that treatment comes more easily to some families than to others. Because of this, we think family culture matters.

So despite the fact that there is not a lot of research on family factors in treatment, we pay attention to the family unit for all our patients (both adults and children). In fact, we now offer this family factor focus not only in our standard OCD treatment, but also in our newly developed intensive outpatient program which we designed to better reproduce and generalize to the patient's home environment. This article will not discuss our program in its entirety, but it will focus on issues relevant to family culture.

Foremost, our approach includes attention to over-involvement with, enabling of, and hostility towards the family member with OCD. It is probably no great surprise that research suggests most family members feel burdened by the OCD sufferer. Also, sufferers with hostile families fare worse than sufferers with supportive families. We focus on increasing awareness of hostile behaviors and on helping families find alternative behaviors to engage in, an important first step towards building a positive family culture.

We also attempt to promote three attitudes in family members that we think are important in hopes that the family members will then help support these attitudes in the person with OCD.

The first attitude is to "embrace uncertainty" and accept the reality that there is no real certainty, no real control, no perfection, and that **THAT IS A GOOD THING**. All anyone can do is one's best right now. That means there is no perfect/right decision because all the possible information is never available right now. You don't get to know how bad (or good) your choice is until later. We try to help families to accept and even enjoy the act of choosing to live right now, to be blissfully ignorant of the consequences that might catch up with them later.

The second attitude is to "let go of normal" and accept that for now, like diabetes, OCD is not curable. Instead, living with OCD means developing a "healthy" lifestyle that makes possible approximating "normal." Making "normal" behavior the goal often leads patients (and families) to reject the most effective exposure exercises. That occurs because the behaviors involved often stretch beyond "normal" and into the unusual, which patients (and families) can erro-

neously perceive as unnecessarily risky. Also, using "normal" as a yardstick does not provide the person with OCD with the right strategies, tools, and attitudes during the maintenance phase, often setting the stage for relapse. For these reasons, we encourage families to drop this longing for "normal" early on and instead focus on developing a family culture that promotes "healthy" and distress-free functioning.

The third attitude that we try to teach is that, contrary to what people usually think, anxiety is and needs to be treated as your friend. Anxiety serves an essential purpose: it keeps you alert and improves functioning in potentially difficult or dangerous situations. But for OCD sufferers, anxiety has become something to avoid at all costs. One should do whatever one can to avoid it or escape from it. We teach OCD sufferers and their families instead to view anxiety as an opportunity or a challenge or an actual chance "to go for it." When families start to view anxious moments as potentially strengthening, it becomes easier to resist colluding with OCD by enabling OCD behaviors. In turn, family members' willingness to approach anxiety-laden situations helps the person with OCD choose to approach his/her triggers instead of avoiding them. Eventually, anxiety will trigger alertness instead of persistent distress.

After helping the family to develop the right attitudes, we look at the actual family culture itself – the family's belief pattern and way of doing things. We believe that OCD can sometimes exploit family cultures. In effect, some family beliefs can provide sheltered ground for symptoms to take root and flourish. In such cases families and patients are actually putting energy and attention into maintaining practices that work against treatment. For example, it will be critical to recovery for an OCD sufferer who fears serious illnesses, who avoids contact with potentially germ-y surfaces and who also compulsively utilizes vitamins and/or herbal supplements, both to risk touching such surfaces and to stop taking vitamins and supplements (at least for a while). But if that OCD sufferer comes from a family that strongly supports taking vitamins and supplements, the family as well as the sufferer may balk at the idea of not taking the vitamins and supplements, insisting that they are essential for good health. Similarly, if an OCD sufferer fears that making a mistake or simply not exerting enough effort will make them fail or become "a slacker," the treatment may call for intentionally "slacking off" and/or making mistakes. But a family that values high achievement, for example, may object if grades or performance start to fall or seem at risk of doing so. Another example is an OCD sufferer with obsessions of worshipping/accepting Satan that are prompted by minor mistakes or by being distracted when praying. For that patient, it will be crucial to recovery to do things that trigger the fearful obsessions and may seem to risk selling one's soul to the devil. But if that OCD sufferer lives in a

(continued on page 13)

RETHINKING THE UNTHINKABLE

(continued from page 5)

In a well-known study done by Freeston, et al. (1997), the treatment consisted of cognitive strategies as well as traditional behavioral strategies. The combining of therapies makes it difficult to know whether the cognitive approach added to or detracted from the patients' recoveries.

Ultimately, as with all forms of OCD, learning to live with uncertainty and risk-taking are the antidotes to this disorder. The treatment of Pure-O is theoretically based on the principles of classical conditioning and extinction. The disorder is perpetuated by the patient's need to try to rationalize and control any random, bizarre and noxious thoughts that occur to him. This intolerance exists due to a misfiring brain function, which makes the patient feel that the thought itself is equal to acting on such a thought. The efforts a person makes to avoid or escape these thoughts reinforce their reoccurrence.

It is a given that a patient's spike will increase when he begins using E&RP. The human is resistant to change. Commonly, a person who, before treatment, would experience spikes many times per day and then ruminate incessantly for the duration of the day, will, after behavior therapy, experience spikes much more frequently, but ruminate much less. The goal of this therapy is not to make the thought go away or to achieve anxiety relief. Although this statement sounds peculiar, it should be repeated often and emphasized during the initial stages of therapy. Rather, the goal of this therapy is to provide specific guidelines for effectively managing this condition so that the brain can naturally readjust to a non-reactive state.

The critical point to be made is that eliminating rumination is the goal, not eliminating the number of spikes! It's how we manage challenges that determines the quality of our lives. The goal of therapy is to not respond to the spike, not to eliminate the existence of the spikes. Interestingly, though, the long-term effect of not attending to the spikes will be that the spikes in fact will decrease in frequency and emotional intensity. However, this will happen only if the person becomes desensitized to these thoughts by allowing them to occur. A common phrase often mentioned in my groups is, "Let the thoughts be there." A patient has to learn to be able to realize that the occurrence of any thought, no matter how bizarre or horrific, has no meaning.

The following useful suggestions are offered towards managing obsessions. The

research is still preliminary, but the treatment outcomes have been significant enough to warrant writing about them. As with all forms of OCD, behavioral therapy is effective to the extent that the patient adheres to the procedures (Dar & Greist, 1992). Since this article's original version, two procedures (index card therapy and spike hunts) have been added to the therapeutic arsenal and have been proven effective. I am just outlining these procedures because behavior therapy needs to be done with an experienced practitioner. Attempting to implement these techniques without expert guidance can be problematic and prevent goal attainment.

1. The Antidote Procedure

The spike often presents itself either as a question or potentially disastrous scenario. A response which answers the spike in a way that leaves ambiguity is the antidote to preventing rumination. For instance, the patient has the thought, "If I don't remember what I had for breakfast yesterday, my mother will die of cancer!" Under the antidote procedure, to manage the obsession, the most therapeutic response a patient can have is to accept this possibility and be willing to take the risk of his mother dying cancer or the question reoccurring for eternity. There is often a question regarding the degree to which one "really needs to believe" that his mother might die. In response, it is important to understand that one's beliefs are really not a significant component of treatment success. Instead, the behaviors and choices one engages in are key to conveying to one's brain that the theme is no longer going to be of any importance. The goal is to expend the least amount of effort in responding to the question. In another example, a spike might be, "Maybe I said something offensive to my boss yesterday." A recommended response would be, "Maybe I did. I'll live with the possibility and take the risk he'll fire me tomorrow." Using this procedure, it is imperative that the distinction be made between the therapeutic response and rumination. The therapeutic response does not answer the question posed by a spike.

2. Let It Be There

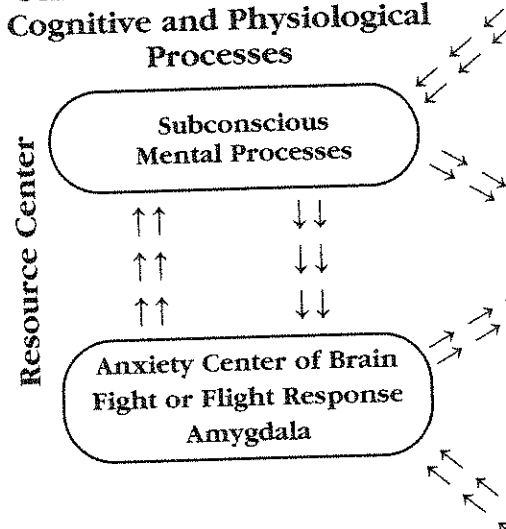
Using this procedure, it is suggested that the person create a mental pigeonhole for the disturbing thoughts and accept the presence of the thoughts into one's pre-conscious (those thoughts which are not currently in one's awareness but can easily be brought there by turning one's attention to them, i.e., your name or phone number). It is suggested that a mental "hotel" be created whereby you encourage your brain to store all the unsolvable questions in order to fill up the register. The more unsolved questions, the better. It is critical that the person suffering from Pure-O

acknowledge the presence of these thoughts, but pay no further attention to them by trying to solve the problems presented by them. The brain can only juggle a certain amount of information at one time. If you purposely overload the brain, rather than going insane, your brain's response will be to just give up trying. A key to this technique is that the person trying it has to have a great deal of faith and trust in the therapist suggesting it.

3. Spike Hunt

Very similar to the "let it be there" approach is the spike hunt. Using this procedure, the patient is encouraged to purposely seek out spikes. This process actually is a 180-degree reversal of the reflexive OCD momentum. Most people with OCD desperately hope for the associations to go away and never return. This frame of mind actually increases the

Schematic Model of OCD's Cognitive and Physiological Processes

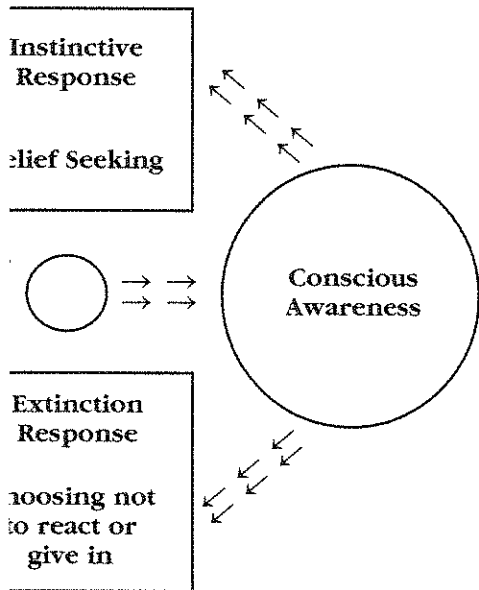


susceptibility of the mind to these thoughts and exacerbates the condition. A good example of a spike hunt is: Patient X is terrified that he might get up in the middle of the night and violently assault his wife and child. He is so fearful that he might act on these thoughts, that any bump or strange shadow in the bedroom prompts him to consider that it might be a place where he's hidden a knife or a gun with which to harm his family. Even familiar objects, which are out-of-place, seem to suggest that he is capable of acting in a non-conscious way and thereby lend support to the idea that his family is in danger of his uncontrollable/non-conscious actions. Using the spike hunt, this patient was instructed to purposely find unidentifiable shadows or mysteriously placed objects and gather

together evidence that the world of the unknown lurks out there and represents possible unforeseen peril. After using this technique for two months and sleeping next to a steak knife (E&RP), the patient achieved approximately 75% symptom relief. The rationale for this seemingly contradictory approach lies in the behavioral principle of reconditioning. Reconditioning retrains the brain to consider its warnings to be non-relevant. For human brains non-relevant information equals experiences that are not perceived.

4. The Capsule Technique

During the initial phases of therapy, there is a great resistance to letting go of the rumination. A way to handle this resistance is to have the person with OCD set aside a specified period of time, perhaps once or twice a day, to purposefully ruminate. It is suggested that the time periods be predetermined and time-limited. The patient



should tell himself "At exactly 8:15 a.m. and 8:15 p.m. I will ruminate for exactly 45 minutes. As thoughts occur to me other times during the day, I can feel comforted that the problem-solving will be given sufficient time later that evening or early the next morning." Typically, people report that it is difficult to fill the allotted rumination time. Regardless, every minute must be spent on the designated topic so the brain can habituate to these irrelevant thoughts. A novel application of this technique was reported in the *Journal of Behavior Therapy and Experimental Psychiatry*. Using audiotaped spiking material, a woman was desensitized to her obsessional themes by exposing herself to them ten times a day. After the fiftieth day, her actual spiking dramatically decreased.

5. Turning Up the Volume

Rather than attempting to escape the spikes, the person with Pure-O is encouraged to purposely create the thought repeatedly following its initial occurrence. One is also encouraged to take the presented topic and actually amplify the threatening component. This has the effect of desensitizing the brain to these spikes by sending the message that not only am I not going to attempt to escape these thoughts; but I am at such peace with them I can create a multitude of them. In response to the thought, "I might have run over someone on my way to work," a beneficial response would be: "There is probably a stack of bodies all along the street. I probably wiped out half the population of my home town yesterday as well. I can't wait to drive home tonight and kill the other half."

6. Index Card Therapy

The index card therapy procedure has been extremely useful in treating people with Pure-O. What baffled behaviorists for years in attempting to treat this form of OCD was that there was no object with which the patient could actually perform an exposure exercise. It seemed rather difficult to have a person touch the thought "Kill my baby" or "I hate God" and then spread it all over the place. To concretize these thoughts, Dr. Foa has suggested using loop tapes in which a patient would sit and listen to his/her particular obsession played over and over *ad nauseam*. The possible limitation of this procedure is that the patient might become habituated to the voice on the tape and not the actual theme represented on the tape. In addition, carrying a tape recorder around with you might be cumbersome and most people do not have an hour each day to sit and just listen to the same message played over and over again. So, to remedy these problems, I created index card therapy, where the patient writes the topic of the spike down on an index card. The patient should also record the date, the intensity of the spike, and the level of resistance to the spike on the index card. The writer carries the index card with him at all times, preferably in a pocket. The patient periodically reviews the index card or cards, usually about six to ten times per day, until the level of associated anxiety and resistance is below a rating of two out of ten for two consecutive days.

Some people report that they have difficulty distinguishing between spikes and "legitimate important thoughts." A fool-proof litmus test for telling the difference is to ask yourself, "Did the thought or question come with an associated anxiety, feeling of urgency or feelings of guilt?" Ultimately, it is wise to place such thoughts in the realm of OCD and make

the CHOICE to accept the risk. When asked, "What if it's not OCD?" I say, "Take the risk and live with the uncertainty." For those who have made significant progress in the Pure-O process, a common complication involves distinguishing a therapeutic response from a ritual.

The E&RP paradigm seems simple. If it makes you anxious, confront it! Create a hierarchy and gradually work your way toward the most challenging items. At some point most Pure-O patients almost always come up with the same question: "Am I doing the therapy correctly?" This is a very common obsessional reaction. The mind tries to throw a monkey wrench into the therapeutic machine by asking the question, "Which is the actual therapeutic response: the performance of an exposure exercise or just accepting the risk?" The ensuing effort to secure the correct answer to this question ultimately can, unchecked, become a time-consuming ritual itself.

To illustrate this dilemma, let's look at the naturally occurring behaviors of blinking and swallowing. For instance, the mind tells the patient to swallow or blink now! The dilemma is as follows: "If I swallow now, won't that be giving into the spike? If I resist giving into the command, then I'm avoiding engaging in the naturally occurring action of swallowing. What's a good patient to do?" The very skilled patient will now accept that all blinks in the future will be the "wrong" blink and accept that all blinks are actually performing a ritual. This choice will influence the brain to stop scrutinizing "getting the therapy right." Ultimately, most Pure-O's and people with a perfectionistic mentality end up spending a great deal of wasted time making sure that they are managing the disorder in a "correct" way. Living in a world of no answers is essential to being able to make a choice and move on.

At this point, the skills of any therapist are not nearly as valuable as the client's willingness to utilize the procedures. Unless a sufferer is thoroughly fed up with the disorder, behavior therapy will be of limited help. Often I have been informed that the treatment is as painful as the disorder. My only response is that with this treatment there is light at the end of the tunnel. The disorder offers only endless suffering. If you find that after six months to a year there is limited movement in a positive direction, it might be worth your while to take a temporary leave of absence from therapy until you are fully committed to letting go of the problem. Published clinical notations suggest that this step might assist in bringing about an increased willingness to confront the nightmare rather than to continue to mentally run away from it.

References for this article are available by emailing perkins@ocfoundation.org.

My OCD Notebook

Loving Someone With OCD

Karen J. Landsman, Ph.D., Kathy Parrish, M.A., and Cherry Pedrick, R.N.



OCD often impacts the entire family, resulting in tremendous confusion and conflict among everyone in the family. It's important to remember, however,

that everyone is trying to cope with the situation the best they can. Through choices made by each family member trying to cope with OCD in the home, OCD can become a family disorder. Fortunately, getting well can become a family effort.

Family members can feel helpless as they watch their spouse or child in the depths of suffering, struggling with obsessive-compulsive disorder. Likewise, people with OCD often feel powerlessness and helplessness in their OCD world. Families are frequently confused about what it means to be supportive, helpful, and therapeutic.

Family members experience a wide range of emotions. They can feel confused, guilty, fearful, angry, doubtful, disappointed, and distraught. They're often filled with heartache; and they may blame themselves or feel blamed by others and burdened by guilt, hostility, or resentment. You might be feeling overwhelmed and helpless, having tried everything in attempts to help your family member. Perhaps your attempts have been ineffective or rejected by your loved one. When this happens, feelings of helplessness and despair grow.

Other family members may be resentful of the attention, albeit negative, that the person with OCD receives. Family members can become overly involved or, alternatively, too distant from each other. Parents may share mutual beliefs and feelings about how to deal with their child's OCD or differ widely in their reactions to the OCD. Or, they may vary their reactions unpredictably between compassion and hostility. Meanwhile, the family dysfunction and chaos grows. Acknowledging negative feelings is an important first step toward choosing healthier, more supportive responses to your loved one's OCD.

Giving in, reassuring or debating are not constructive ways to help decrease the symptoms of OCD. These efforts at support are in fact OCD accommodations in disguise.

Let's take a closer look at the natural, intuitive approaches to supporting your loved one with OCD. These are often accommodating behaviors and can be likened to an "OCD Welcome Wagon." You essentially invite OCD

into your home and make it comfortable through your accommodations. Just as you try to make an old friend or other guest feel comfortable and welcome in your home, you extend yourself to OCD and its demands. It's as if you cater to OCD as you would a guest: "What can I do for you? What can I get for you? Anything you need, just let me know." The more comfortable you make the OCD, the longer it wants to stay in your home.

When we say you may be accommodating, we're referring to any of your behaviors or reactions to OCD symptoms that can undermine the therapeutic goal of exposure and risk-taking. It is a way of paying undue respect to OCD and its demands on you and your loved one. Accommodating supports OCD, not the person with OCD. By changing these behaviors, you are making a conscious decision to support your loved one instead of the OCD. You may actually act as if you're scared of your family member's OCD, when you may really be fearful of his or her reaction to the obsessions. Or, perhaps, you're really trying to protect your family member from the unfounded fear.

Accommodating behaviors occur quite naturally and make sense at the time. Your attempts at helping are genuine and come from the heart. They sometimes give you a sense of control over a virtually uncontrollable situation — a situation that has left you feeling fearful, helpless, and exhausted. No "small" accommodation is ever truly small. Each accommodation serves as "food" for the OCD and any "feeding" is meaningful and serves to help OCD grow stronger. Here is one example of accommodating behavior that often occurs in families.

Accommodation Trap: Providing Reassurance

How often do you find yourself telling your loved one something to make him/her feel better, such as answering the same questions over and over again? "Yes, I am sure that you checked that the stove is turned off." "Yes, I'm sure you washed your hands well enough." "Yes, I'm sure that you didn't make a mistake." "Yes, I am sure you said the numbers in the right order." "Yes, I'm sure they do not have AIDS." This is what we refer to as repeatedly reassuring your loved one. He or she may ask you the exact same question over and over again, or repeatedly reword the question in many different ways. Sometimes, your response even becomes part of the ritual so that there are rules about how your reassurance should be worded.

Reassurance involves assurance of the unfounded nature of the obsessive thoughts and fears. Your loved one may seek reassur-

ance that the ritual itself was performed correctly and/or that the feared outcome will not happen. Reassurance reinforces the "fear messages" sent by the "worry" part of the brain. The "worry" part demands that they make certain of something that could otherwise have terrible consequences. You help provide that demanded reassurance and certainty.

When trapped in the cycle of reassurance, you may feel like you're talking to someone who just isn't listening or is of limited intelligence. A more accurate way to think about this trap is that you and your loved are creating a skip on a record, and one of you needs to move the needle ahead to continue the song. To move ahead, you both must recognize the reassurance trap for what it truly is and agree that risk-taking and exposure is the way to move past the moment. Remember, when you give reassurance, you reduce the risks of uncertainty that have to be confronted head-on. By reducing the risks that need to be confronted through exposure, you feed the OCD.

You may find yourself trying incessantly to drill your loved one with logic against the unfounded fear through rationalizing and arguing with the OCD. You're struggling with the OCD rather than your loved one. They're also struggling with the OCD. You're trying to reason logically and debate with someone who is reasoning by feelings alone in that OCD moment. Family members report the frustration of trying to rationalize away fears, which sometimes will "work" for a short period of time. The unfortunate fact that rationalizing sometimes appears to work in the short-run only serves to reinforce its use. That means that the next time you and your loved one are in a similar OCD situation, you're more likely to react with a rational debate or argument instead of risk-taking. Debating works along the same lines as giving reassurance.

Beware! Accommodating reactions are often a short-term fix to a longer-term problem. They may work at first, but as the demands of OCD increase, you will have to make more and more of an effort to accommodate OCD in just the "right" way. By stepping in to protect your loved one from OCD, you are modeling the belief that he or she cannot cope in other ways. You model the belief that your loved one needs to be protected and shielded from the fears. The message sent is that your loved one is too weak and too vulnerable to cope with the fears, the uncertainty, and the risk-taking required to overpower and overcome OCD.

The above is an excerpt from "Loving Someone with OCD," to be published in 2004, written by Karen J. Landsman, Ph.D., Kathy Parrish, M.A., and Cherry Pedrick, R.N. Dr. Landsman can be reached at (973) 895-2442 and practices in Westfield and Chatham, New Jersey. Kathy Parrish can be reached at (610) 667-6490 at The Anxiety and Agoraphobia Treatment Center in Bala Cynwyd, Pennsylvania.

How I Treat OCD

Comprehensive CBT for Trichotillomania

Nancy J. Keuthen, Ph.D., Chief Psychologist, OCD Clinic and Research Unit, and Co-Director, Trichotillomania Clinic, Massachusetts General Hospital and Harvard Medical School, Charlestown, MA



In my experience, the treatment of trichotillomania (or "trich") can be a challenging and, at times, frustrating endeavor for sufferers and professionals alike.

Patients often approach treatment with considerable shame and apprehension given past histories of negative reactions from family ("You could stop if you only tried harder") and even from professionals ("Pulling out your hair reflects a wish to harm yourself"). Prior treatment failures are not uncommon, making it difficult for sufferers to embark on treatment for a second time. From the caregiver perspective, treaters face a paucity of research to illuminate the nature of trich and to help guide treatment. For many of us who spent years treating OCD before treating trich, we have been accustomed to the more robust CBT outcomes for OCD and can be humbled by the limitations we face in reducing the suffering of our trich patients.

So why then should trich sufferers pursue CBT? Despite my opening remarks, I firmly believe that CBT for trich is well worth the effort. A well-trained and experienced cognitive behavior therapist can effectively reduce the patient's shame, facilitate more constructive perspectives on the disorder, instruct in more functional coping strategies, encourage involvement of other sources of support, and help diminish associated avoidance.

I structure CBT as a collaborative process during which the patient and I work together to first uncover his or her "signature" pattern of pulling. I define my role as that of an educator and coach emphasizing the pivotal role of the patient in his or her recovery from trich. I introduce self-monitoring of symptoms as a method to establish baseline frequency, identify hair pulling patterns (habit-like pulling with decreased awareness or binge-like

pulling accompanying intense emotional states), and develop early awareness. Training in early recognition of urges and associated triggers will provide the sufferer with the best chance of intervening more effectively in the future to control the pulling behavior.

Although pulling frequency may diminish simply in response to monitoring assignments (a phenomenon called "behavioral reactivity"), lasting control over trich only occurs when solid CBT skills are acquired. I begin treatment (after brief psychoeducation on the nature of trich) by instructing patients in the essentials of Habit Reversal Training (HRT), a treatment package first popularized by Drs. Nathan Azrin and Gregory Nunn. In addition to awareness training, the essentials of HRT include identification of, and practice with, a competing response (i.e., a motor behavior that is incompatible with hair pulling such as making a fist), as well as relaxation training. Along with HRT, I instruct patients in Stimulus Control procedures. Essentially, these are techniques that involve modifying the puller's environment to enhance awareness or decrease opportunities to pull. For example, it can involve limiting pulling triggers (e.g., applying Band-Aids or wearing hats), providing cues to increase awareness (e.g., tying a ribbon on the steering wheel if pulling occurs while driving), or providing behavioral alternatives (e.g., playing with a Koosh ball or manipulating string or textured fabric).

While HRT and Stimulus Control techniques can significantly reduce symptoms, my experience has been that they do not sufficiently address pulling in reaction to strong emotions when greater numbers of hairs are extracted. To more effectively treat pulling that functions as a maladaptive way to control emotions, I have recently begun to incorporate techniques adopted from Dr. Marsha Linehan's Dialectical Behavior Therapy (DBT). More specifically, I often use mindfulness training to further enhance awareness of urges and behavior, facilitate decentering from anxious thoughts, and promote acceptance-based perspectives. DBT techniques designed to help with emotion regulation (e.g., increasing positive emotions, "letting go" of emotional suffering, and reducing emotional vulnerability) are also effective. Lastly, I also implement DBT strategies to improve distress tolerance (e.g., self-soothing, distraction, "improving the moment," and identifying pros and cons).

Once hair pulling behavior is significantly reduced through use of CBT skills, I instruct patients in relapse prevention strategies (modeled after the work of Dr. Alan Marlatt and colleagues in addiction research). I discuss the difference between "lapses" (temporary setbacks in hair pulling control) and "relapses" (loss of all gains with return to baseline functioning). Patients are asked to complete a matrix identifying all the short- and long-term pros and cons to pulling hair vs. controlling hair pulling. They are instructed to anticipate setbacks (especially early on in treatment), to preemptively identify high-risk situations, and to design effective behavioral strategies for coping with lapses. Lastly, I discuss with patients the importance of early intervention after setbacks to prevent the occurrence of more severe hair loss that, in turn, can further undermine one's motivation.

Finally, I'd like to suggest a few other treatment guidelines that I have found helpful in treating trich. First, I always discuss treatment expectations before I begin intervention. Appropriate expectations are defined as symptom control or management as opposed to a "cure." Unrealistic expectations often result in patients becoming frustrated and terminating treatment early. Second, I encourage patients to establish interim, short-term goals (e.g., routinely use stimulus control procedures when studying) to make the process of treating trich more manageable and less overwhelming. Third, I emphasize that one should focus more on one's compliance with self-monitoring and behavioral treatment strategies, rather than reductions in pulling frequency counts or hair regrowth. This is important for several reasons: trich is known to be a waxing and waning disorder; unanticipated life stressors may temporarily challenge one's ability to manage urges; different techniques may be more or less effective depending on the individual and their pattern of pulling. Also, hair regrowth can be delayed depending on the growth cycle during which the pulling occurred. And lastly, I routinely recommend the involvement of outside support systems when possible, whether family or support groups, to provide greater accountability and more frequent reinforcement to help sustain ongoing symptom management both during and after treatment.

Dr. Keuthen is author of the self-help book for trichotillomania "Help for Hair Pullers." She can be contacted at Massachusetts General Hospital at 617 726-4074 or by email at: nkeuthen@partners.org.

Dr. Coric Talks About New Research Studies At Yale

The following is an interview with Dr. Vladimir Coric of the Yale Clinical Research Unit.

NEWSLETTER: We talked a year ago about the study you were doing at the Yale Clinical Neuroscience Research Unit on the efficacy of Riluzole (Ritulek) for treating OCD. Can you explain to our readers what kind of drug Riluzole is and why you decided to see if it was effective in managing OCD symptoms? How far along is that study now? What results do you have so far?

DR. CORIC: Riluzole is a potent antiglutamatergic agent initially FDA approved as a neuroprotective agent for patients diagnosed with amyotrophic lateral sclerosis. Glutamatergic hyperactivity is thought to contribute to the neural circuitry dysfunction underlying OCD. Neuroimaging studies have consistently identified increased blood flow, metabolism and brain activity in the cortico-striato-thalamic (CST) neural network of individuals with OCD. Within these brain areas, glutamate and GABA driven pathways are thought to be responsible for balancing neural tone. One model regarding the pathogenesis of OCD suggests that overactivity in the glutamatergic pathway results in a self-perpetuating neural circuit between brain regions that drives OCD symptoms.

Thus, we hypothesized that persistent OCD symptoms in individuals who have failed to respond to treatment with serotonin reuptake inhibitor (SRI) medications may be the result of a failure to adequately dampen glutamatergic hyperactivity. Based on preclinical and neuroimaging studies, we postulated that a drug that directly decreases glutamatergic hyperactivity might be a safe and effective strategy in treating refractory OCD.

To date, nine individuals have completed the riluzole study and our preliminary data has recently been submitted for publication. The individuals who enrolled in the study represented a very treatment refractory group (with most failing multiple medication trials, cognitive behavioral therapy and augmentation with dopamine antagonists). We are encouraged by the preliminary results of the study; four out of nine study participants demonstrated a significant treatment response to augmentation with riluzole. In those four patients who responded to treatment with riluzole, the percent decrease in Y-BOCS scores

ranged from an approximately 38-76% reduction in symptoms. There was no significant worsening of OCD symptoms in those individuals who failed to respond to treatment. Additionally, riluzole was well tolerated and all individuals who entered the study completed it without serious adverse events. It is important to note that these results are only preliminary findings. We are undertaking a large, prospective, placebo-controlled, double-blind study to follow-up our initial results and verify the study findings.

NEWSLETTER: Are you still conducting this study? Can individuals with OCD still sign up for this program?

DR. CORIC: Yes, the study remains open and individuals with OCD can still sign up.

NEWSLETTER: What criteria does someone have to meet to participate in this study?

DR. CORIC: Individuals with a primary diagnosis of OCD who have not adequately responded to standard treatment with SRI medications are candidates for the study. The study is offered on both an inpatient and outpatient basis. Both the inpatient and outpatient programs involve augmenting the patient's current SRI medication with riluzole. Outpatients must be available to come in for weekly ratings.

NEWSLETTER: How long is this study?

DR. CORIC: The study has been expanded to twelve weeks in duration.

NEWSLETTER: Will participation in this study cost the patient anything?

DR. CORIC: All study treatment is free of charge. Additionally, individuals admitted to the inpatient program will also receive meals and room/board free of charge.

NEWSLETTER: What other studies are you and your team involved in at the Research Unit?

DR. CORIC: Our team on the Yale Clinical Neuroscience Research Unit has developed two additional treatment studies for individuals with OCD. One study examines the effectiveness of memantine, a NMDA receptor antagonist, in the treatment of OCD. The second study looks at the effectiveness of dronabinol, a cannabinoid receptor agonist, in treating individuals with treatment refractory OCD.

NEWSLETTER: What is memantine? What kind of drug is it? Why do you think this drug will be effective on OCD? Have there been any other studies on memantine's effect on OCD? What are the results of these studies?

DR. CORIC: Memantine is an NMDA glutamate receptor antagonist recently approved for the treatment of Alzheimer's disease. Like riluzole, the possible efficacy of memantine in OCD is based upon the hypothesis that decreasing glutamatergic hyperactivity might be a safe and effective strategy in treatment refractory OCD. Whereas riluzole is thought to work by decreasing glutamate release, memantine is thought to work by selectively blocking the excitotoxic effects associated with abnormal glutamate neurotransmission and by allowing for the physiological transmission of glutamate associated with normal neuronal functioning.

There have been no studies to date examining the effectiveness of memantine in OCD.

NEWSLETTER: Are there any risks or side effects associated with this medication? What are they?

DR. CORIC: Memantine has been shown to be well-tolerated in patients treated for Alzheimer's Disease. Some adverse effects included: hallucinations (2%), confusion (1.3%), dizziness (1.7%), headache (1.7%) and tiredness (1.0%).

NEWSLETTER: Who is sponsoring this study?

DR. CORIC: At this point, the study is funded by the Yale Clinical Neuroscience Research Unit and the Connecticut Mental Health Center. Forest Pharmaceuticals, the maker of memantine, is considering supporting the study as well.

NEWSLETTER: What is dronabinol? What kind of drug is it? Why do you think this drug will be effective on OCD? Have there been any other studies on dronabinol's effect on OCD? What are the results of these studies?

DR. CORIC: Dronabinol is thought to work by activating the brain's naturally occurring cannabinoid receptors. Two cannabinoid receptors have been characterized in the brain to date: the CB1 cannabinoid receptor and CB2 cannabinoid receptor. The CB1 receptor is pri-

marily thought to be localized in the central nervous system with high concentrations in the areas of the brain implicated in the pathophysiology of OCD (basal ganglia, striatum, globus pallidus). Basic evidence suggests that activation of CB1 receptors within the striatum reduces striatal glutamatergic outflow, inhibits GABA reuptake, and enhances GABA neurotransmission. We hypothesize that activation of the CB1 receptor may decrease the excessive striatal activity seen in OCD. Muller-Vahl et al have examined the effectiveness of dronabinol in the treatment of Tourette's disorder and also reported an improvement in study participants' Y-BOCS scores as well.

NEWSLETTER: Are there any risks or side effects associated with this medication? What are they?

DR. CORIC: Some adverse effects may include increased heart rate, hallucinations, confusion, cognitive changes, "feeling high," dizziness, fatigue, and diarrhea.

NEWSLETTER: Who is sponsoring this study?

DR. CORIC: The study is sponsored by the Yale Clinical Neuroscience Research Unit and the Connecticut Mental Health Center.

NEWSLETTER: What are the criteria for participating in either the memantine or dronabinol study as a patient?

DR. CORIC: For both studies, individuals with a primary diagnosis of OCD who have not adequately responded to standard treatment with SRI medications are candidates for the study.

NEWSLETTER: What is the duration of the trials? Can someone participate as an outpatient or only as an inpatient?

DR. CORIC: Both trials are twelve weeks in duration, and open to either inpatients or outpatients.

NEWSLETTER: Will some of the participants be getting a placebo? Will the people who get a placebo be able to try the study medication? If the placebo group will not be given an opportunity to try the medication, what do they have to gain from participating in the study?

DR. CORIC: Both studies are an open-

label design. All participants in either study will receive active medication. There is no placebo.

NEWSLETTER: If a patient shows improvement with the use of the medication, will she be able to continue with the medication after the trial? Will it be provided free of charge?

DR. CORIC: If the participant demonstrates a treatment response, we will provide a prescription for a two-week supply of the medication and recommend to the participant's primary treatment provider that the treatment be continued on an outpatient basis. Medications will not be provided free of charge after completion of the study. However, it may be covered under an individual's insurance policy as an off-label use of the medication.

NEWSLETTER: Your program is basically a research program, not a treatment program. Will you continue to treat patients who have shown no significant improvement after the trial is completed? Will you offer alternative treatments or medications?

DR. CORIC: Patients who show no significant response after the study trial will be offered the opportunity to stay for a prolonged period for an alternative clinical treatment if appropriate.

There is currently no formal follow-up or aftercare once the study is complete. Study participants will be referred back to their primary treatment provider. The study team, with the participant's permission, will communicate with the primary provider regarding the participant's treatment response or lack of treatment response. We will also provide treatment recommendations to the primary provider if requested.

NEWSLETTER: Will cognitive behavioral therapy play any part in the trials?

DR. CORIC: All subject participants will receive an individualized behavioral treatment plan.

NEWSLETTER: If someone is interested in taking part in either study, whom should they contact and how?

DR. CORIC: Individuals interested in the study should contact the study coordinator, Suzanne Wasylink, RNC, at (203) 974-7523.

How We Treat OCD

Family Culture Matters

(continued from page 7)

devoutly religious family, family members may encourage him/her to live with these symptoms rather than take such risks.

In such situations, we believe that working with the family to shift its priorities is necessary. For the time being, we tell them it is more important to help the OCD sufferer fight his/her OCD than to make sure he/she is adhering strictly to the family's pattern of beliefs and value systems. It may be necessary, for awhile at least, to support the OCD sufferer's therapy even if there is a conflict between it and the values the family espouses. One approach to this goal is to help families recognize that the patient's OCD may actually be working against or sabotaging adherence to the family values anyway. For example, for the patient with religious obsessions, it may help if the family can recognize that praying has become more about fear of Satan than love of God and that minor mistakes are being treated as more sinful than intentionally disobeying all of the Ten Commandments. For the patient afraid of failing or becoming "a slacker," it would be helpful if the family view could shift to accept that the fact that failure will be MORE likely if the patient continues to be miserable and dysfunctional. Additionally, the family may need to accept the risk that some failure may close the door to a cherished goal (perhaps NOT getting into medical school or getting an academic scholarship), but realize at the same time that if the sufferer does not take control of his OCD, it will rob him of any chance to be successful or accomplish any of his goals. Unfortunately, this is a real possibility. Some OCD sufferers have achieved their academic goal of graduating from medical school but have been unable to pursue a medical career because of their uncontrolled OCD.

In our intensive program, we often encourage (and have tried to make more financially feasible) involving family members actively in treatment too, so that we can help modify the family culture and/or help the patient learn how to use his/her anti-OC skills and attitudes within the family culture. Hopefully, this will reduce the risk of relapse.

We hope these examples have illustrated how family culture can become a treatment impediment for some people with OCD. We encourage families to find ways to break their own rules gradually as the sufferer moves through treatment. Often this comes down to family members being willing to do mini exposure and response prevention exercises themselves. Engaging in commensurate exercises goes a long way towards creating momentum and helping create a family culture conducive to recovery.

Drs. Fitzgibbons and Street can be contacted at Anxiety Solutions of Northern New England, P.L.L.C., Bethlehem, NH, (603) 991-3227.

PLEASE CONTRIBUTE TO THE
OCD GENETICS COLLABORATIVE

From The Foundation

(continued from page 1)

part in the in the family studies being carried out at Brown University, Columbia University, Johns Hopkins University, Massachusetts General Hospital, the National Institute of Mental Health, UCLA and UC San Diego.

Second, you can make a contribution to the OCF Genetics Collaborative to help underwrite the cost of the Collaborative's second meeting which is scheduled for April 23-24, 2004, in Arlington, VA. At this meeting, genetic researchers from all over the world will be working together and sharing what they have learned. Despite much recent work, an OCD gene or genes has not been found. This does not mean that there is not a genetic component in OCD, but rather that there is much more work to be done. You can help this work get done by contributing to the OCF Genetics Fund. We need to raise at least \$55,850.00 to cover the meeting's costs. This is the amount we've budgeted to cover the cost of this meeting which include transportation, lodging, meals for more than 40 investigators and the rental fees for the necessary audio-visual equipment.

Please take this opportunity to become a part of this very important research by participating in a family study and contributing to the OCF Genetics Collaborative.

Ciao.

Patricia Perkins

"OCD In The Classroom" Only 246 Left at the Subsidized Price

As of the date the OCD NEWSLETTER went to press, there were 246 copies of "OCD In The Classroom" program still available out of the 500 that were assembled. Only the first 500 of these kits are being sold at the subsidized price of \$15.00 plus shipping and handling for members and \$25 plus shipping and handling for non-members. We were able to price these programs designed to "educate the educators," so affordably because the project was underwritten by the Lupin Foundation, the Perakis Family Foundation, Bernie and Edna Bahr and everyone who bought a raffle ticket at the 10th Annual OCF Conference. Once these initial sets are sold and we reorder, the price will increase to reflect the actual cost of producing them. To order, contact Leslie at (203) 401-2070, ext. 14.

The 2004 OCF Annual Art Exhibit and Contest*

At the 11th Annual OCF Conference
July 23-25, 2004
Chicago, Illinois

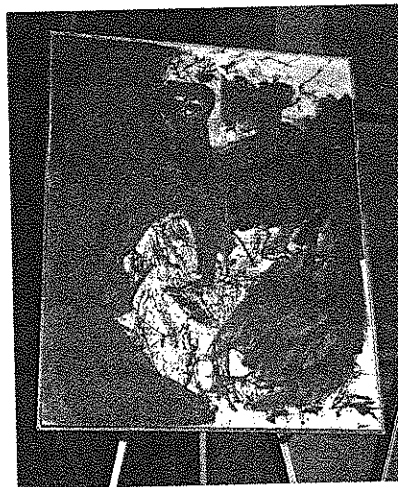
First Prize: \$1,000.00

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 Exhibit/Contest. 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) 401-2069, or email her at cole@ocfoundation.org. The application fee is \$10 per entry.



First Prize - 2003



Second Prize - 2003



Third Prize - 2003

* Sponsored by Patrick Johnson

BULLETIN BOARD

(continued from page 2)

- sweating
- nausea or vomiting
- shaking, trembling, or tingling
- feeling out of control
- feeling unreal
- fear of dying or going crazy

What is social anxiety disorder? SAD consists of being fearful and/or uncomfortable around others. People with SAD find it hard to be at work or school. Symptoms include:

- intense fear of doing or saying something embarrassing in front of other people
- being afraid of making a mistake and/or being watched and judged by others
- avoiding doing things you want to do or speaking to others
- worrying for days or weeks before you meet new people
- blushing, sweating, trembling, or feeling nauseous before and when meeting new people
- avoiding social situations and giving speeches
- often drinking to make your social fears less severe

Can I participate?

If you have the symptoms of panic disorder or social anxiety disorder and are 21-65 years old, please contact us! You could be eligible to participate in our study.

What does participation involve?

A member of our team will ask you questions to determine your eligibility for the study.

If you are eligible and want to participate, we will ask you to sign a consent form and fill out two brief questionnaires.

After you sign and return the consent forms and questionnaires, you will undergo a detailed interview with a trained clinical interviewer regarding your psychiatric and medical history.

We will get a small blood sample from you.

All of this can be done from the comfort of your own home. The interview can be conducted over the telephone; and, we have a service that will come to you for the blood draw. We even reimburse people who participate \$75 when they complete all of the steps.

All of the information obtained will be confidential and no identifying information will ever be included on the interview or the blood, which will be used to extract DNA. Genes are hereditary material made of DNA that are passed from parent to child. Shared genes from family members with similar characteristics such as hair and eye color also may increase the susceptibility to certain diseases. The analysis of the DNA will be guided by the information we will be learning from the laboratory. We hope to be able to determine how genes matter.

If you think you are interested, contact via mail, telephone or email:

Dana March
1051 Riverside Drive, Unit 24
New York, NY 10032
Phone: (212) 543-6520/5020/5078
gafs@childpsych.columbia.edu

This study has been approved by the New York State Psychiatric Institute Board and Columbia University Institutional Review Protocol #4495.

MEDICATION STUDY AT EMORY UNIVERSITY SCHOOL OF MEDICINE

Philip T. Ninan, MD, director of the Mood and Anxiety Disorders Program at Emory University School of Medicine, Department of Psychiatry and Behavioral Sciences, is conducting a medication study. The purpose of the study is to determine the effectiveness of a medication that may be beneficial in treating obsessive compulsive disorder in patients who have not had a satisfactory response to an adequate trial of at least one anti-OCD medication. Participation could last up to 8 weeks.

Who is Eligible?

In order to be eligible for the study, one must be between the ages of 18-65 years old, meet diagnosis for OCD as primary (to be determined by evaluation), currently taking an SSRI medication, and living in the Atlanta, GA area or within 1-2 hours of Atlanta, GA.

What are the Benefits?

Participants will receive a psychiatric evaluation, a physical exam, laboratory tests and study medication at no cost.

Contact Information:

Alison Long, Patient Recruiter
Mood and Anxiety Disorders Program
Emory University School of Medicine
1841 Clifton Rd.
Atlanta, GA 30329
Phone: 404-712-MOOD (6663)
Fax: 404-727-3700
E-Mail: studies@emoryclinicaltrials.com
Website: www.emoryclinicaltrials.com

ESCITALOPRAM FOR THE TREATMENT OF SELF-INJURIOUS SKIN PICKING

The Massachusetts General Hospital OCD Clinic and Research Unit is conducting an open-label trial of escitalopram (Lexapro) in the treatment of self-injurious skin picking. This disorder is characterized by repetitive picking or scratching at skin that results in bleeding, scarring, and/or infections.

We are seeking adults between the ages of 18-65 who have been skin picking for at least 6 months. Subjects must live within commuting distance of the Boston area and must not be taking any medications for psychiatric disorders. Subject participation lasts 18 weeks and involves a total of seven visits to the MGH OCD Clinic. All participants receive a comprehensive psychiatric evaluation and treatment with escitalopram at no cost. Please call Rebecca Loh at (617) 726-9281, if you believe you are eligible for this study and would like to participate.

WE'RE LOOKING FOR FILMS FOR THE 4TH ANNUAL OCF FILM FESTIVAL

The 11th Annual OCF Conference is only a few months away (July 23-25, 2004). And, we are starting to plan the 4th Annual OCF Film Festival. We've scheduled it for Saturday night after the Reception.

We are looking for films* on any topic by directors and writers with OCD or an OC Spectrum Disorder. We also want to feature films about OCD or an OC Spectrum Disorder. We are interested in screening FEATURE FILMS, DOCUMENTARIES AND ANIMATED MOVIES. We're looking for films that run at least 15, but no more than 75 minutes.

If you are a filmmaker/writer or actor who is interested in having his/her work shown at the 4th Annual OCF Film Festival at the 11th Annual OCF Conference in Chicago on Saturday night, July 24, 2004, contact Patricia Perkins, executive director, at perkins@ocfoundation.org or call her at 203-401-2074 for more information.

* Not previously shown at an OCF Conference.

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