

Interview with the New President of the OCF Board of Directors



Joy Kant of Newton, MA, was elected president of the OCF Board of Directors at the Board's Annual Meeting on February 28, 2004. She will serve as president of the OCF Board of Directors for

the next two years. The following is an interview with Mrs. Kant in which she describes how she became involved with the OCF and what her vision is for the Foundation

Q. How did you first get involved with the OC Foundation?

A. After my son was diagnosed with OCD, I looked for places to find out more about OCD. It was at that time, I discovered that there was a foundation that specifically focused on helping individuals with OCD as well as the families that were directly affected by the disorder.

Q. You were the treasurer of the OCF Board for the past two years. How do you think serving in that position will affect how you lead the Foundation?

A. Serving as the Foundation's treasurer for two years gave me the opportunity to work directly with the staff at the Foundation and to understand the importance of fiscal stability. I was also fortunate to observe and to learn from the leadership example of Jan Emmerman, our immediate past-president.

Q. Since you have been on the board, what programs and projects have you been most involved with?

A. Since I have been on the board, I have attended the Carter Center Symposium on Mental Health, represented the Foundation on a cable talk show, "Nite Beat," with several OCD investigators and doctors, helped to form the Genetics Collaborative and accompanied the executive director, the former board president and Dr. Michael Jenike to Rockville, MD, to meet with Dr. Thomas Insel, the director of NIMH.

Q. On what projects and programs do you want to focus the Foundation's energy over the next two years?

A. I would like to see the Foundation:

- Increase its membership,
- Work more directly with pediatricians in identifying children with OCD,

(continued on page 5)

From The Foundation

Dear Friends,

By the time you are reading this, you will have received a copy of the 11th Annual OCF Conference Registration Brochure. Hopefully, you've read through it and are planning to join us at the Conference in Chicago, July 23-25, at the Hyatt Regency Hotel on the River Walk.

But in case you haven't made up your

mind already to attend, let me tempt you with a little preview of what we have planned. Dr. Thomas Insel, director of the National Institute of Mental Health, is going to be our Keynote Speaker this year. We are really excited about this not only because Dr. Insel is one of the country's leading psychiatrists, but also because he was one of the pioneers of OCD research. We made a pilgrimage down to

(continued on page 14)

**DON'T MISS THE
11TH ANNUAL OCF
CONFERENCE
JULY 23-25, 2004
AT THE
HYATT REGENCY HOTEL
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Featuring

**Thomas Insel, MD
Director of the National Institute
of Mental Health
As the Keynote Speaker**

**76 workshops, presentations and
support groups**

**Separate tracks
for**

**Adults with OCD
Family members
Children with OCD**

**Adolescents and Young
Adults with OCD**

**Treatment providers and Mental
Health Professionals**

Art Contest and Exhibit

**OCD Camping Trip with Jon
Grayson**

**For more information and a
Registration Brochure, call Mary
or Leslie at 203-401-2070, Ext.
11 or 14. Or go to www.ocfoundation.org
and download a copy of
the Registration Brochure.**

In This Issue

- Bulletin Boardp. 2
- How I Treat OCDpp. 3, 8, 9, 12
- "Overcoming Hoarding"p. 4
- Research Digest.....p. 6
- My OCD Notebookp. 10

Bulletin Board

STUDY ON CO-OCCURRENCE OF OCPD AND OVERVALUED IDEAS AMONG INDIVIDUALS WITH SCRUPULOSITY

The Center for Cognitive Behavioral Psychotherapy (CCP) is conducting a study exploring the co-occurrence of Obsessive Compulsive Personality Disorder and overvalued ideas among individuals with religious scrupulosity.

What is Obsessive Compulsive Personality Disorder?

Individuals with OCPD live their life with an attachment to a strict code of law. Specifically, such individuals are overly attached to the laws of God, the government, society, or other powers. Perfectionistic thinking patterns create a disruption to one's quality of life, and the lives of those around them.

What is Religious Scrupulosity?

Scrupulosity is a form of OCD where individuals fear being sinners for not properly observing religious practices. Such individuals often repetitively perform religious rituals in order to provide temporary relief from fear. However, the fear ultimately returns and the repetition continues.

What are Overvalued Ideas (OI)?

OI is a phenomenon experienced by certain individuals with OCD that is characterized by the individual's belief that the obsessional thought is legitimate or rational.

Who is eligible?

If you have a diagnosis of OCD (Scrupulosity subtype) and are 18 years old or older, you are eligible to participate in this study. You do not need to live in New York. The research objectives can be achieved via mail.

What does participation involve?

Participation in the study will involve the completion of three simple paper-pencil questionnaires, and will take no more than 30 minutes.

What are the ramifications of this study?

The ramifications of this study will be to further our understanding of how personality disorders, OCPD in particular, and overvalued ideas potentially impact the treatment success of individuals with OCD. In doing so, we

hope to advance our understanding of how treatment techniques may need to incorporate and/or be sensitive to OCPD and OI.

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OCD INSTITUTE GETS LARGER BUILDING

The MGH/McLean OCD Institute located in Belmont, MA has moved to a larger building on the McLean Hospital campus. Due to the ongoing demand for residential and partial hospital services for adult patients with OCD, the hospital accommodated the program's need for additional space. The expanded program can now house 20 patients, up from 17 in the old building. This move has significantly decreased waiting times for the program. If you are interested in obtaining information or applying for the program, please contact Diane Davey, RN, MBA at 617-855-3279 or davey@ocd.mclean.org.

DOES SOMEONE YOU CARE ABOUT HAVE OBSESSIVE-COMPULSIVE DISORDER, BUT WON'T SEEK HELP?

You may qualify for participation in a study to evaluate the effectiveness of an intervention to help families deal with an OCD sufferer who will not seek help. Consultation is provided to interested family members at no charge, if they qualify for the study. If you think you might qualify or would like further information, contact Paula Eslich at 314-534-0200 or at paulae@slbmi.com. This research study is being underwritten by an OCF Research Award. This study is being conducted at Saint Louis Behavioral Medicine, St. Louis, MO.

**This newsletter
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A COPY OF THE OFFICIAL FLORIDA REGISTRATION AND FINANCIAL INFORMATION OF THE OBSESSIVE COMPULSIVE FOUNDATION, A CONNECTICUT NON-PROFIT CORPORATION, MAY BE OBTAINED FROM THE DIVISION OF CONSUMER SERVICES BY CALLING TOLL-FREE WITHIN FLORIDA 1-800-435-7352 OR 1-850-488-2221 IF CALLING FROM OUTSIDE FLORIDA. REGISTRATION DOES NOT IMPLY ENDORSEMENT, APPROVAL OR RECOMMENDATION BY THE STATE OF FLORIDA. THE OCF FLORIDA REGISTRATION NUMBER IS SC-09749. THE OCF DOES NOT HAVE A PROFESSIONAL SOLICITOR. ONE HUNDRED PER CENT OF EVERY CONTRIBUTION IS RECEIVED BY THE OCF. DONATIONS WILL BE USED TO UNDERWRITE THE OCF'S PROGRAMS, ACTIVITIES AND OPERATIONS AS WELL AS FOR RESEARCH.

OCD NEWSLETTER

The OCD Newsletter is published six times a year.

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The Obsessive Compulsive Foundation (OCF) is an international not-for-profit advocacy organization with more than 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 treatment and to open a dialogue among practitioners and researchers as well as patients and their families on the best ways to treat OCD. We invite our readers to submit articles describing the way they treat OCD. Anyone interested should call Jonathan Grayson, Ph.D. at (610) 667-6490, or email him at drjg17@hotmail.com.

Outpatient Treatment for OCD: Flexibility is a Virtue

By Jonathan Abramowitz, Ph.D., ABPP
OCD/Anxiety Disorders Program
Mayo Clinic
Rochester, MN



It is fantastic that more and more therapists are providing cognitive-behavior therapy (CBT) for OCD. We know from lots of well conducted research studies that CBT (particularly exposure and response prevention) is, over-

all, the best available treatment for OCD. However, not all outpatient CBT programs are created equal. In some instances, patients can only get to see their therapist every couple of weeks. Other patients receive weekly or twice-weekly sessions. Still others receive a more intensive version in which treatment sessions occur daily over a specified amount of time, usually about 3 weeks. There is an additional issue of therapist-assisted CBT versus self-directed treatment. In some instances, therapists spend the session coaching patients through their exposure practices. Additional exposure, usually an extension of the exercises completed in session, is typically prescribed for homework. In other cases, the therapy session is spent devising exposure tasks for the patient to practice between sessions as homework, and there is no in-session exposure.

What is the "best" approach? This will depend on whom you ask. There are research studies that can be interpreted to support the effectiveness of a number of different approaches (although on average, the most symptom reduction is typically found with the intensive, daily session regimen). But, clinically speaking, the "best" approach for one patient is not necessarily the "best" approach for another. Let me explain what I mean. Just as treatment programs vary from program to program and therapist-to-therapist, people with OCD vary greatly in many ways. Patients pre-

sent with different kinds of symptoms (e.g., washing, checking or both); they vary in how much insight into the senselessness of the fears they have and how readily they are willing to take initiative in confronting their fears to reduce their symptoms. I believe that each of these variables needs to be considered carefully when developing a program for an individual person with OCD. In other words, rather than offering the same regimen of treatment (intensive, self-directed, or otherwise) to every person with OCD, I think the best approach is for the therapist to be flexible. This might mean using different approaches at various times in therapy. Below, I share some thoughts I have about when self-directed and intensive treatment (the two extremes of the spectrum) should be used.

Self-Directed Treatment

In self-directed treatment the therapist and patient spend most of the therapy session developing exposure practices for the patient to complete as homework assignments. Very little, if any, exposure occurs in the session, or under the therapist's direct supervision. I do not think CBT treatment for OCD should entail only self-directed exposure. My main concern is that without the therapist's supervision, patients might avoid the very anxiety-evoking elements that they must confront to make the most out of exposure. This is understandable since it is these situations that patients have been trying to avoid for many years. Not only that, patients may not recognize some of their behaviors as ritualistic or avoidant and may apply these during self-exposure, thinking it is OK to do so, yet actually (unknowingly) sabotaging the exercise. This is especially true if the patient does not fully understand the rationale behind doing exposure to reduce OCD symptoms.

That being said, I believe that once therapist-assisted exposure is initially successful, it is beneficial to teach patients to do self-directed exercises because ultimately patients must learn to tackle their fears on their own and in multiple settings (this is the idea behind exposure homework). In fact, I see one goal of CBT as teaching patients how to be their own therapists. This means that they design and conduct exposures on their own, and routinely employ habits of confronting feared situations rather than avoidance and rituals. With some patients, I find I can hand over

the "reigns of therapy" more quickly than with others. In particular, I am most comfortable with moving toward a more self-directed approach when the patient demonstrates initiative in designing his own exposure tasks, clearly understands the rationale for facing his fears, and shows that he is willing to confront even his most feared situations.

Intensive Treatment

Within OCD treatment circles, intensive therapy usually means spending 3 to 4 hours of initial assessment and treatment planning, followed by about 15 two-hour sessions of therapist-directed exposure and response prevention. Intensive treatment is highly systematic and directive. I believe the major benefits of intensive treatment are: (a) that the therapist oversees the in-session exposure practices to ensure that even the most feared situations are properly confronted, and (b) that any habits such as avoidance and rituals can be corrected within a day as opposed to the following week. These qualities likely lead to the formidable response with this type of treatment. However, there may be some limitations of intensive treatment as well. First, three weeks of daily treatment might limit the opportunity to generalize what is learned in therapy to situations outside the session. Treatment delivered over 8 or 12 weeks would allow for practice with exposure in a wider variety of "real-life" situations. Second, interesting research on how people learn suggests that when learning is concentrated over a brief time, we do not retain the information as well as when learning takes place over an extended period of time. This suggests that perhaps beginning with an intensive schedule and gradually progressing to a less rigorous schedule, ending with self-controlled exposure, would be the optimal treatment program.

Of course, there are some instances when intensive CBT is necessary. In our program, patients come from across the country and it is desirable to keep their stay at our center as brief as possible in order to return them to their home environment and regular routine (as well as to control the cost of housing). Thus, for our national patients, we offer intensive treatment (usually 3-4 weeks). Another instance when we recommend intensive treatment is for patients who believe they will have extreme difficulty handling the distress

(continued on page 8)

Book Review

Overcoming Compulsive Hoarding

by Fugen Neziroglu, Ph.D., Jerome Bubrick, Ph.D. and Jose Yaryura-Tobias, M.D.

Reviewed by Renae M. Reinardy, Psy.D. Dr. Reinardy treats children, adolescents and adults with anxiety disorders and leads the hoarding program at the Behavior Therapy Center of Greater Washington in Silver Spring, Maryland.

Compulsive hoarding is a fascinating and understudied behavior that involves the acquisition of and failure to discard possessions that appear to have no or limited value. To be considered as clinically significant, hoarding must result in impairment in functioning or cause significant distress. Hoarding is believed to be relatively common in clinical and nonclinical populations and seems to occur along a continuum. Individuals with compulsive hoarding are distinguished from other savers by the quantity of objects saved, the dysfunction caused by clutter, and their strong attachment to objects that most people would consider useless.

Very little information exists on the treatment outcomes of people with hoarding problems. In comparison to other obsessive-compulsive behaviors, compulsive hoarding is believed to be a more difficult condition to treat (Frost & Steketee, 2000). Hoarding is a complex phenomenon that has been found to predict poor treatment response. Hoarding is a well-established pattern of behavior that usually has occurred for many years by the time the person seeks treatment.

Overcoming Compulsive Hoarding by Fugen Neziroglu, Ph.D., Jerome Bubrick, Ph.D., and Jose Yaryura-Tobias, M.D. is a much-anticipated book for compulsive hoarders, their families, and clinicians who are interested in learning more about the treatment of this disorder. I was pleased to be asked to review this book and believe that it can be useful for individuals with mild to moderate difficulties with hoarding. This is an easily understood book that offers practical suggestions in an interactive format.

Overcoming Compulsive Hoarding provides readers with general information on compulsive hoarding, cognitive-behavioral therapy, and is a step-by-step structured guide to decluttering living space, preventing new clutter, keeping cleaned areas free from clutter, and preventing relapse. In my experience working with hoarders, one of the main difficulties frequently encountered in the treatment is the hoarders' struggles to declutter on their own. This book serves as a self-help guide that will likely be a helpful adjunct to therapy and a way to make progress

when the person who hoards is not in therapy. However, I believe that readers should understand that hoarding is often a challenging behavior to change and not to give up if they do not succeed on their own in trying to gain more control over this behavior.

The information provided in the book assists the reader by first discussing the key symptoms of compulsive hoarding and providing stories of two hoarders to demonstrate differences in how hoarding can be manifested. The reader is provided with an exercise to better understand his or her own hoarding symptoms. The authors then go on to describe the differences between hoarding and collecting behaviors, the different types of hoarding behavior, and conditions associated with compulsive hoarding. Through this information and exercises provided, the reader is better able to answer one of the important questions posed in the book, "Are you a hoarder?"

The authors also briefly describe the important biological and sociological aspects of hoarding in a way that is easily understood and free from unnecessary jargon. I found the section titled, "A Sociological Look at Hoarding," particularly interesting because it challenged readers to rethink how they view possessions and challenged the societal view that happiness is achieved through the acquisition of possessions. The consequences frequently experienced by compulsive hoarders are also discussed to highlight the difficulties experienced by hoarders and their families. Later in the book, the authors expand on the consequences of hoarding and emphasize the importance of treatment, either for the person who hoards or for family members of a hoarder. In addition, they provide some helpful advice on how to persuade a resistant hoarder to seek treatment. I believe that this is an important issue that should be further explored in other literature on hoarding.

Several reasons why people save their possessions are discussed and exercises are provided to assist the reader in identifying his/her own saving style. The traits commonly found in hoarding are highlighted in this book and include the fear of losing information, indecisiveness, the fear of making a mistake, the inability to prioritize tasks, fear of loss, fear of memory loss, and lack of organization.

After the reader has some basic knowledge about hoarding, the authors do a good job of describing the treatment options that have been scientifically studied to treat

this behavior. The components of cognitive behavioral therapy are discussed in an understandable way and techniques, such as, exposure and response prevention (ERP) are described. Emphasis is put on cognitive restructuring and readers are provided with the message that "how we think affects the way we feel, which affects what we do." Motivational aspects are also discussed and exercises are provided to help the reader become more aware of his/her self-talk and the pros and cons of changing his/her behavior.

Treatment strategies that require action on the part of the reader make up a good portion of the book. I believe that the strategies and techniques discussed are useful and often essential in overcoming aspects of hoarding. Readers are guided through identifying their automatic thoughts, recognizing the feelings associated with these thoughts and situations that elicit automatic thoughts. Readers are educated about cognitive distortions and are guided through an "experiment" designed to challenge maladaptive/unhelpful thoughts. This process helps the reader to arrive at a rational response that encourages a positive outlook and challenges the automatic thought. This exercise is nicely outlined in a user-friendly format and incorporates the use of flash cards that can be used throughout the self-help treatment process described in the book.

The book also provides readers with a systematic guide titled, "Cleaning up the Clutter." Preparation and suspending the acquisition of new items assist the reader in setting up a successful plan of attack on his/her hoarding. Several suggestions are made that will assist the reader in tackling his/her hoarding problems in manageable, organized steps. Reinforcement is also an important part of the process; and the authors suggest some strategies that may help individuals stay motivated during the difficult task of decluttering. The authors introduce some helpful strategies to help with the excavation process originally outlined by Frost and Steketee. While some of the suggestions may be difficult to comply with, it is clear how they would be helpful in decreasing churning and avoidance behaviors.

The authors also did a wonderful job of emphasizing the importance of maintenance by reminding readers that "the actual cleaning process is only half of the work; the other half is maintaining the progress you've made." Suggestions were made on selecting target areas and how to make decisions on specific items such as

Overcoming Compulsive Hoarding

clothing, magazines, newspapers, paper and plastic bags, and multiples of items.

Once the decluttering and cleaning process is complete, readers are guided through the organizational process with the items they have kept in their "save" boxes. As with the other steps in the book, this stage is also set up in a structured format. This is the part of the book that readers may have difficulty waiting for since individuals may be tempted to organize before the decluttering and cleaning process is complete.

Daily, weekly, and monthly cleaning goals are suggested to help maintain gains and prevent clutter from reaccumulating. Readers are cautioned to keep working on the strategies outlined in the book to prevent relapse and address tendencies that may result in the return of clutter. Acquisition is also briefly addressed and so is how ERP can be helpful in decreasing compulsive acquisition.

While this book is written in a user-friendly manner, compulsive hoarding is often a complex problem that requires much self-motivation, energy, and time. The authors make the point that the reader will be most successful by working through the book in a methodical way. This book would be a valuable tool for hoarders who have mild to moderate symptoms, without serious comorbid disorders, and who are ready to take action on their hoarding problem. In addition, this book is also a helpful guide for therapists to facilitate change in clients who hoard, and for family members to better understand how they can be of help in decluttering and maintaining a comfortable home.

Overall, this book is a welcome addition to the literature on compulsive hoarding. As compulsive hoarding becomes better understood and clinicians, researchers, and individuals who hoard share the factors thought to contribute to this behavior, the better equipped we will be to manage this disorder. As with all self-help books, it is important to work toward empirically validating the effectiveness of self-help therapies that hoarders self-administer or that therapists use as an adjunct to therapy.

The authors are experts in obsessive-compulsive spectrum disorders and Drs. Neziroglu and Yaryura-Tobias have been important contributors through their numerous publications on obsessive-compulsive disorder and related disorders. The authors' knowledge and clinical experience are demonstrated through helpful information and strategies shared throughout the book.

Interview with the New President

(continued from page 1)

- Provide more Behavioral Therapy Institutes, especially in remote parts of the United States,
- Help raise money for research and the OCF Genetics Collaborative,
- Encourage the membership to get involved in lobbying Congress to pass legislation requiring parity in insurance coverage,
- Set up a public relations campaign to inform those who have OCD that the OCF is available to help them and their families,
- Encourage parents to use our program, "OCD in the Classroom," to teach the teachers how to react to students with OCD, and
- Increase the Board's size to 15 members, focusing on geography, diversity, interest and skills.

Q. What are the Board's goals for the next two years?

A. I see the Board's goals for the next two years as being to work on and bring to fruition the projects and programs I outlined above, i.e.:

- Growing membership
- Promoting research
- Supporting the work of the Genetics Collaborative
- Working to promote parity in insurance coverage
- Encouraging educators to help students with OCD
- Raising money to support important research projects that will produce effective treatment for everyone with OCD
- Getting the word out to the public about OCD

Q. How are you going to achieve these goals?

A. I hope to encourage board members to form committees covering each of the goals I've outlined above. I also hope to encourage OCF members to volunteer to work on these committees and make it easier for members to get involved in many of the Foundation's programs and projects.

Q. How important is supporting research for the Foundation?

A. Raising money for research is extremely important because the ultimate goal of the OCF is to provide effective treatment for everyone with OCD.

Q. How do you propose to raise money to support the Foundation's Research Program and the OCF Genetics Collaborative?

A. I would like to encourage families of individuals with OCD to have fundraisers. People can have a "Coffee and Talk," undertake a letter-writing campaign, hold a gala, or put on a golf tournament. I want to encourage our members to be as creative as they want. And, I will promise support and help from the Board and the OCF staff for any event someone wants to do. A few years ago, I held a "Coffee and Talk" in my home. Dr. Michael Jenike came and spoke about OCD and the Foundation. Many of the people who attended the event said that it was very informative and that Dr. Jenike was great. At that event, we raised over \$32,000. In September of 2003, I did a letter-writing campaign to raise money for OCD Research Program and the OCF Genetics Collaborative. Friends and family contributed about \$12,000 in response to my letter.

What I want the membership to know is that everyone can help raise money. The way you do it depends on what you are comfortable doing. Many individuals, families and foundations have already given generously of their time and money to support our Research Program and the OCF Genetics Collaborative.

Q. Is developing an active volunteer base one of your goals? How do you plan to do this?

A. Yes, it is one of my goals. We want to utilize this year's OCF Conference in Chicago to interest people in becoming more active in the Foundation's programs. Conference attendees come from all over the country. We're going to be talking with people this summer and listening to them. Hopefully, we will be able to recruit new volunteers there.

Q. How can OCF members get actively involved in the Foundation's work?

A. Members can read the OCD Newsletter, sign up for the research trials, start and attend support groups, distribute information about OCD, organize affiliates, send letters to their senators and representatives requesting their support on parity legislation, and hold fundraisers to raise money for research and the OCF Genetics Collaborative.

Q. What one thing do you really want to accomplish during your term as president?

A. This is a very difficult question to answer. I would love to see legislation passed promoting parity on insurance coverage. Unfortunately, I am afraid that this will be the hardest goal to accomplish unless, working together, we can enlist the support of business, industry and the government.

Research Digest

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

Antidepressant medications in children

New England Journal of Medicine, 350:1489-1491, 2004, B. Vitiello and S. Swedo

There are concerns that selective serotonin reuptake inhibitors (SSRIs) may cause suicidal behavior in children. In 2003, the U.S. Food and Drug Administration (FDA) cautioned physicians to avoid prescribing paroxetine (Paxil) for children (an off-label use of paroxetine); and when discontinuing paroxetine treatment in adults, to discontinue slowly so that withdrawal reactions could be avoided. In March of this year, the FDA requested that labels on SSRIs include a warning that all child and adult patients should be "monitored closely for worsening depression or the emergence of suicidality." Drs. Vitiello and Swedo give their perspective on the safety of SSRIs in children, discussing safety as a relative concept to be considered in light of the severity of the disorder and the benefits and risks of the treatment. For OCD, they believe the balance appears favorable: fluvoxamine (Luvox), sertraline (Zoloft) and fluoxetine (Prozac) have been shown to be effective in children and are approved by the FDA for this use. The picture is less clear for the treatment of depression as the benefit in depression is less clear than in OCD and because there is increased risk of suicide in depression. A causal link between SSRI use and suicidal behavior has not been proven by current data (no suicide has ever been reported among the more than 4,100 subjects enrolled in pediatric clinical trials of SSRIs). In fact, the increased use of antidepressants in children 10 to 19 years old has been associated with a decreased suicide rate. Each percent increase in SSRI use in this age group has been accompanied by a decrease of 0.23 suicides per 100,000 per year. Nevertheless, SSRIs have been associated with an increased rate of adverse behavioral effects such as nervousness and agitation. It is possible that the nervousness and agitation that occur in some children treated with SSRIs might have the potential to increase the risk of self-injurious acts, and physicians should monitor patients carefully for such adverse effects.

Family approaches to treatment for obsessive compulsive disorder

Journal of Family Psychotherapy, 14(4):43-50, 2003, G. Steketee and B. Van Noppen

Drs. Steketee and Van Noppen review research on family aspects of OCD, focusing on issues that pertain to behavioral treatments for adults. There is evidence that family hostility, emotional over-involvement and criticism perceived by the patient can negatively affect behavioral treatment outcome. Family accommodation (assisting with or supporting rituals) predicted poorer family functioning and more severe OCD symptoms after behavioral treatment. Although not well researched, family education and supportive therapy are suggested to be useful for families and patients. Based on research findings, authors recommend psychoeducational interventions for family members who are unfamiliar with OCD, who accommodate to a patient's symptoms and who tend to be critical and/or negative in their attitude. Therapists should use behavioral contracting in which family members agree aloud on who does what with whom to limit rituals and family involvement. Therapists should discourage excessive behavioral and emotional involvement to ensure that patients take responsibility for therapy decisions. Family therapy may be needed to support relatives in dealing with frustrating patient behaviors and to encourage more positive family communication. Multifamily group therapy appears to be an efficient and cost-effective form for providing family behavior therapy.

Cognitive behavior therapy for hypochondriasis: a randomized controlled trial

JAMA, 291:1464-1470, 2004, A.J. Barsky and D.K. Ahern

Hypochondriasis, a persistent, irrational fear or belief that one has a serious, undiagnosed medical illness, is a prevalent disorder affecting as many as 5% of medical outpatients. Similar to OCD, hypochondriasis involves obsessions and compulsions – obsessions about being ill and compulsions to check with others for either diagnosis and treatment or reassurance that one is not ill. Individual cognitive behavior therapy (CBT), administered

in six 90-minute sessions to 102 subjects with hypochondriasis, was compared to medical care as usual for 85 subjects. The CBT sessions focused on factors that cause patients to exaggerate bodily symptoms and misattribute them to serious disease. Subjects were assessed before and 6 and 12 months after completion of treatment. At the 12-month follow-up, CBT patients had significantly lower levels of hypochondriacal symptoms, beliefs, and health-related anxiety. They also had significantly less impairment of everyday functioning. Hypochondriacal attitudes and concerns improved more than occurrence of bodily symptoms did. This finding was expected as the treatment was intended to improve patient coping with symptoms rather than curing the disorder. This study supports the use of CBT for hypochondriasis to lessen patient fears and beliefs and improve coping.

Exposure with response prevention versus habit reversal in Tourette's syndrome: a controlled study

Behaviour Research and Therapy, 42:501-511, 2004, C.W.J. Verdellen, G.P.J. Keijsers, D.C. Cath et al.

Tourette's syndrome (TS) is a neurological disorder characterized by tics (quick seemingly involuntary movements) or vocalizations (verbal outbursts or sounds) that occur repeatedly. Most tics are preceded by unpleasant sensations and urges (stimulus); and the performance of tics (response) relieves these sensations. Interrupting the stimulus-response sequence is the aim of behavior therapy. In this study two forms of behavior therapy are compared; exposure and response prevention (ERP) is compared to habit reversal (HR) in 43 Tourette's syndrome patients. In ERP, the assumption is that prolonged exposure to premonitory stimuli with tic suppression results in habituation to the sensations and urges, and a tic reduction. In HR, the assumption is that tic reduction is obtained by use of a competing response after the first signal that a tic is about to occur. Both ERP and HR were effective behavioral strategies in the treatment of tics. The results of this study support the use of behavior therapy as a treatment for TS.

WEBSITE ON COMPULSIVE HOARDING GOES LIVE

Appearing on your computer monitor screen now! The newest addition to the OCF website, www.ocfoundation.org, is the Compulsive Hoarding Website. This website, which is devoted to the understanding and treating of compulsive hoarding, is edited by Drs. Gail Steketee and Randy Frost. Drs. Steketee and Frost are leaders in the research and treatment of compulsive hoarding. Dr. Steketee is a professor at the Boston University School of Social Work where she chairs the Clinical Practice department. Dr. Frost is currently the Harold Edward and Elsa Siipola Israel Professor of Psychology at Smith College. Working together, Drs. Steketee and Frost have developed a treatment program for compulsive hoarding. The funding for this work was provided by the OC Foundation and the National Institute of Mental Health. They have also written together *Cognitive Approaches to Obsessive Compulsive Disorder: Theory, Assessment and Treatment*.

The website that went live May 8, 2004, contains articles about the nature and

treatment of compulsive hoarding by some of the most experienced practitioners in this field, including among others: Gail Steketee, Ph.D., Randy Frost, Ph.D., Sanjaya Saxena, M.D., Karron Maidment, RN, MA, Renae Reinardy, Psy.D., Charles S. Mansueto, Ph.D., Nicholas Maltby, Ph.D., and David Tolin, Ph.D. Other investigators and treatment providers who contributed articles to the "Compulsive Hoarding" Website are: James Claiborn, Ph.D., Todd Farchione, Ph.D., Ancy Cherian, MA, and Shawnee Basden, BA.

Dr. Fred Penzel, author of *OCD: A Complete Guide to Getting Well and Staying Well*, contributed the feature article, "Langley Collyer: The Mystery Hoarder of Harlem," which can be downloaded and read. The site also contains an assessment scale, "Saving Inventory-Revised," an important tool for treatment providers who are working with people who suffer from compulsive hoarding.

There is also a section on Support Groups and Personal Recovery featuring

articles on how to organize on-line or "brick and mortar" support groups for compulsive hoarders as well as several personal success stories by people who are compulsive hoarders or have recovered from compulsive hoarding.

The website also contains a Research Digest edited by Bette Hartley, MLS, and John H. Greist, M.D., from the Madison Institute of Medicine. This feature contains abstracts on the latest published research on compulsive hoarding-related topics. There is also an "Ask The Experts" section that includes questions about hoarding with answers written by members of the OCF Scientific Advisory Board.

The funding for this webpage came from membership dues and contributions as well as a specially designated donation from Marby Causey. The Compulsive Hoarding Website was designed and set up by Al Willen of Virtually Yours.

Go to www.ocfoundation.org, scroll down to SIGS, and then click onto "OCF's Hoarding Website" to learn about compulsive hoarding and its treatment.

Research Digest

A placebo-controlled cross-over trial of adjunctive EPA in OCD

Journal of Psychiatric Research, 38:323-325, 2004, M. Fux, J. Benjamin and B. Nemets

For depression, several studies have shown beneficial effects of eicosapentaenoic acid (EPA), a component of omega-3 fatty acids found in fish oils. Eleven patients with OCD participated in this study. All were on a stable dose of a selective serotonin reuptake inhibitor (SSRI) with no further improvement over at least the past two months. In addition to their SSRI medication, patients were randomly assigned to receive 6 weeks of placebo followed by 6 weeks of 2 grams of EPA or the addition of EPA followed by placebo. No significant improvement was found with adding EPA. This study does not support the use of EPA, fish oils or omega-3 fatty acids as add-on treatments for OCD. It does not address the question of EPA without SSRIs as an OCD treatment.

Prevalence of obsessive-compulsive disorder in patients with systemic lupus erythematosus

Journal of Clinical Psychiatry, 65:301-306, 2004, M.J. Slattery, B.K. Dubbert, A.J. Allen et al.

Based on evidence of basal ganglia dysfunction in both OCD and systemic lupus erythematosus (SLE), researchers expected that the occurrence of OCD would be high in patients with SLE. Fifty adult patients with SLE completed a self-report questionnaire adapted from the Yale-Brown Obsessive Compulsive Scale and an in-person clinical interview.

Compared to a 2 to 3% prevalence in the general population, OCD was 10 to 15 times more common in this group of patients with SLE - 16 patients (32%) met criteria for a diagnosis of OCD at some time in their life and an additional 5 (10%) met criteria for sub-clinical OCD. None of the patients had been previously diagnosed with OCD. Nearly one half of the patients had reported a history of depression to their physicians, but none had reported his/her OCD symptoms. There is a need for improved recognition of OCD symptoms in patients with SLE, and

this study suggests that patient self-report questionnaires would be helpful in screening for OCD symptoms.

Association of small life events with self-reports of tic severity in pediatric and adult tic disorder patients: a prospective longitudinal study

Journal of Clinical Psychiatry, 65:426-431, 2004, P.J. Hoekstra, M.P. Steenhuis, C.G.M. Kallenberg et al.

Severity of tics tends to "wax and wane" over time. It has been assumed that this fluctuation in tic severity is related to stress. Two groups of patients, 32 adults and 25 children age 7 to 16 years, participated in this study that examined the relationship between stress and tic severity over a 12-week period. Contrary to traditional views, in general, stress resulting from the occurrence of life events did not account for changes in tic severity. In only a minority of tic disorder patients did fluctuation in symptom severity appear to be associated with stressful small life events.

How I Treat OCD

(continued from page 3)

associated with exposure, especially if it appears this will interfere with treatment compliance. Finally, for patients with extreme difficulty resisting compulsive rituals, or who have excessively elaborate avoidance habits, we consider intensive treatment.

Conclusions

In conclusion, I do not think that a one-size-fits-all approach is best when it comes to providing CBT for people with OCD. On the one hand, the therapist needs to be concerned about ensuring that exposure is prolonged and repeated in a therapeutic way and that it includes the most feared items; or else, the door is open for relapse to occur. While this might argue for doing intensive therapy for everyone, there are some concerns with daily treatment that might also lead to long-term problems such as failure to generalize and dependency on the therapist. This leaves the therapist with the important task of titrating the intensity of treatment based on the factors I reviewed above. However, to increase the effectiveness of treatment, it is also important for patients to be open and honest about how they are doing with exposure and response prevention and whether they need the therapist's help. After all, it is the patient who stands to profit (or suffer) the most.

The Importance of the Treatment Community



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It has been clearly established and well documented by leaders in the field, such as, Isaac Marks

and Edna Foa, that behavior therapy is effective in reducing OCD symptoms. Research predicts that around 75 percent of patients report marked improvement. This leaves about one-fourth of the OCD sufferers who, for various reasons, do not benefit from behavior therapy. It is well-known that pharmacotherapy is an effective treatment, particularly, when serotonin reuptake inhibitors are utilized. For these medications, the effectiveness reported is approximately 50 to 70 percent, which leaves a sig-

nificant percentage not helped by serotonin reuptake inhibitors. Thus, there are effective treatments available; but there are still many OCD sufferers who are not helped by them. Furthermore, about 30 percent of patients refuse or discontinue individual behavior therapy, reporting that it is too difficult or that they are too fearful to engage in the direct exposure to the fears that behavior therapy requires.

My treatment approach toward OCD is evidence-based and rooted in behavior therapy. For the last several years, my focus has been on trying to help those OCD sufferers who have failed other forms of treatment. As the director of a specialty hospital program at the Menninger Clinic for patients with severe OCD and, frequently, with serious comorbid disorders, I treat patients who struggle with extremely severe symptoms who have often failed in outpatient treatment – whether the treatment has been intensive or gradually self-directed. The centerpiece of my treatment program is providing an environment where the patient is enabled "to stay the course" and do the difficult work that is needed for treatment to be effective. We, the treatment staff at the Menninger Clinic, strive to create an atmosphere for change that enables the patient to complete his or her exposures and allows for habituation and symptom reduction. This "culture of change" comes from a unique blend of support and encouragement received from fellow OCD sufferers that is complemented with feedback from the multi-disciplinary treatment team.

The functional assessment, which sets the stage for the development of a hierarchy of OCD triggers from which a preliminary treatment plan is created, is used pretty uniformly by cognitive behavior therapists. The answers to questions, such as, "What is the obsession?" and "What triggers your OCD?" drive the plan of action. They also dictate which exposures are to be focused on first and create a general idea of the progression of the treatment. This forms the essence of each person's individualized treatment and the results inform the ongoing treatment process.

After assessing a patient's OCD triggers and fears, a more formal plan is created. This "Behavior Treatment Plan" - the road map for the treatment - delineates the hierarchy, core problems, specific obsessions, compulsions, avoidances, goals and specific interventions. This is a fluid and flexible plan that continues to evolve throughout the course of treatment. Usually, therapists have patients start with an OCD trigger that produces a low to mild level of anxiety – often around 4 to 5 on an anxiety rating

scale, which runs from 1 to 10. This is the one we use at Menninger Clinic.

However, due to the debilitating nature of some OCD symptoms, I have often had no choice but to begin with the patient's most debilitating or challenging symptom. For instance, there was one patient who has not taken showered in several months because showering was so labor intensive and time-consuming. Each shower lasted several hours. Because the patient had to be able to bathe, we attacked this symptom first, even though it was very high on the anxiety rating scale. It should be noted that you cannot start out with a high anxiety symptom unless the patient is willing. Often the anxiety rating is high for such a trigger, maybe 7 to 10. This makes completion of such a task without compulsions very difficult without adequate support.

In my experience, difficult exposures such as these need to be repeated daily for the best results. These very difficult interventions can be very tiring to family members and other caregivers who do not have the time available to provide the necessary support. We can do these difficult types of exposures at Menninger because we have 24-hour staff support. We have found this intensive approach to be highly effective because it often gives patients a significant reduction in their OCD, allowing them then to focus on other OCD triggers or issues.

The Behavior Treatment Plan contains information and a plan of action to assist patients through their morning and evening routines with minimal ritualizing. The plan also lays out how to implement staff-assisted exposure and ritual prevention sessions. Typically, in our model, the cognitive behavior therapist works closely with the patient to update his/her ever changing and transforming hierarchy of OCD triggers. Both therapist and patient are responsible for the integrity of the E&RP session. Because of the nature and severity of our patients' OCD and a history of treatment failure, every effort is made to preserve the integrity of the E&RP session.

A personalized "Treatment Contract" supplements the Behavior Treatment Plan. The patients have a leading role in designing the objectives for the week and implementing the contract. Philip Levendusky proposed such a role in his "Client as Colleague" model. The patients set very specific objectives for the week to help them tackle some of their OCD triggers, improve their overall health and address aftercare. Patients receive weekly feedback about their progress toward the goals from fellow patients and the staff. These group feedback sessions are, based

How I Treat OCD

(continued from page 8)

on our experience and supported by some preliminary findings, a powerful therapeutic vehicle in providing motivation for the patient to change and accept increasing amounts of control over his treatment and recovery. This is especially true for patients with very severe treatment-refractory OCD who have previously failed outpatient treatment. This format provides opportunities for modeling by "senior" patients who are further along in their treatment, accountability to their peers and staff, as well as a very clear format in which to provide constructive feedback.

The treatment community (sometimes called the milieu) appears to be very powerful in instituting change and in motivating patients who previously have been unable to do E&RP. Interventions applied in the treatment community specific to challenging OCD symptoms include: physical environment, staff interventions such as ritual blocking, support and understanding of peers and staff, education, group and team work, containment and 24-hour supervision if needed, camaraderie, and safety. These interventions contribute to the "culture of change," while maintaining a safe treatment community where patient and staff work collaboratively toward treatment goals.

Treatment interventions and group work are naturally based on the diagnosis and symptoms with which each patient presents. In that regard, several diagnostic-specific and symptom-specific groups have been created for patients to further enhance their treatment. Patients, adolescents and adults alike, have repeatedly stated that these groups have been particularly helpful. These groups provide a unique opportunity to create support and reduce the false beliefs patients often hold about the nature of their symptoms.

It is very clear to me that alliance and collaboration are essential elements in an effective treatment program. This is because we are basically asking patients to face what they fear most and to live with uncertainty. These elements support the patient while he is trying to complete E&RP sessions, resulting in habituation and symptom reduction. The best way I have been able to create such an alliance is through genuine empathy, education about the CBT model, practice, and reliance on the treatment community or peers. Peers are helpful in convincing those who are just entering treatment that success is possible. Self-efficacy (i.e., the belief that one can successfully complete an E&RP session) is enhanced through social persuasion and

seeing others being effective in mastering their OCD symptoms. This enhancement of self-efficacy is best achieved, I believe, when it occurs in a group of individuals facing similar challenges. Our data are convincing in demonstrating the effectiveness of the program in helping many patients who have failed outpatient treatment; and this no doubt is true of the other inpatient programs.

The mission of the specialty hospital program at Menninger Clinic is to create a "culture of change" in which the OCD sufferer is surrounded by caring and understanding staff members who have empathy for his struggles. This promotes effective implementation of E&RP sessions. Equally important are the sufferer's peers. Not only do they provide a special form of empathy; but they are often the source of the most intense challenges to the most resistant OCD symptoms. This "culture of change" is very different from the "culture of helplessness" in which sufferers often find themselves. Frequently, family members and other caregivers are exhausted and do not have the wherewithal to adequately support the treatment efforts. Coming to a specialty hospital provides sufferers with a type of "fresh start" in a new context. Many sufferers have been socially isolated and struggling with debilitating OCD for years; and, therefore, in need of other psychosocial treatments that are aimed at treating the whole person.

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When A Sufferer Has OCD with Comorbid Anxiety Disorders



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One of the most helpful skills I learned while I was doing clinical research with patients with OCD was to evaluate and listen for the other anxiety symptoms, which often intensified

or complicated the OC patient's experience and report of distress with the obsessive and compulsive symptoms. What does the clinician do when the patient presents with OCD, Panic Disorder and Social Phobia?

The treatment of OCD is often complicated because of the nature of the comorbidity that exists with OCD. Cognitive behavioral treatment of OCD that co-occurs with panic attacks, Panic Disorder, and Social Phobia presents a challenge to the therapist. The lifetime prevalence comorbidity of Social Phobia and OCD is estimated to be 10.5%, while the comorbidity of OCD with Panic Disorder is estimated to be 13.8%.

How do I treat cases of OCD with comorbid anxiety disorders? I develop a plan for implementing protocol-based treatments targeted at the specific symptoms, such as, OCD. When improvement occurs for the target symptoms, I sequentially introduce the protocol-based treatments for the comorbid anxiety, such as, Panic Disorder or Social Phobia. I start the treatment with a full evaluation of the symptoms, level of functioning and distress; and I use the semi-structured diagnostic instruments and self-report measures to assist in the evaluation. I use the Anxiety Disorders Interview Schedule (ADIS-R for DSM IV), the YBOCS interview and self-report as well as self-report instruments that assess panic attacks, Social Phobia and general level of anxiety and depression. After the evaluation is complete, I discuss, "What the patient wants the therapy to accomplish?" These results are agreed upon; and a treatment goal is developed.

In this process, I answer the following questions: What disorder should I address first? How and which interventions are to be used?

As I begin the treatment, I systematically identify the patient's underlying beliefs and the relationship between the beliefs and the manifestation of the symptom of anxiety.

Once the relationship between the obsessive thought, the panic attack or the social situation is established and the beliefs driving the anxiety cycle are specified, the structure for planning the cognitive behavioral treatment is based on identifying the anxiety cycle and breaking the cycle down into its components, which are the trigger event, the thought, the physical sensations/emotions, and the behavioral response.

Each symptom cluster whether it is OCD or Panic Disorder or Social Phobia is analyzed and understood with this structural model. For example, let's look at the situation where a person with OCD, who is concerned about contamination from bodily fluids, walks by someone who has just left a public bathroom and thinks that he might

(continued on page 11)

My OCD Notebook

Why Try?

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Are you tired of doing things in a ritualistic manner? Yet, at the same time, do you feel you must listen to and do what the OCD is telling you to do? Are you frustrated with not being able to go out and do things that

friends or family are doing because it might trigger an unwanted thought or urge? Do you feel you can't quite bring yourself to do an activity which might generate discomfort and anxiety? Do you dream about what you would like to accomplish in life, but feel trapped?

Treatment for OCD is not easy. However, it can get easier over time. Reducing the extent to which the OCD interferes in one's life involves behavior therapy, specifically, exposure and response prevention (E&RP) treatment. Put simply, as with any type of fear, the way to reduce your fear is to face your fear. In OCD treatment, it is important to do response prevention, i.e., resist the urge to do what the OCD is telling you to do. Whether you employ a gradual exposure to triggering thoughts, images, situations, and activities or the more intensive "flooding exposure," with repeated practice, E&RP will reduce triggers that used to generate high levels of fear and anxiety to little or no anxiety (habituation). Treatment involves learning as much as you can about your particular types of obsessions. Learn the subtle and not so subtle rituals you do as a result of your obsessions. Are you avoiding doing things in life? In treatment, others can teach you what you need to do to reduce the OCD symptoms. But only you can decide when you are ready for this, where you can find the internal determination to fight it and when the time feels right to do this.

So, why challenge the OCD if you are feeling it's going to take too much effort? Why bother to face your fears of impending danger, disease or death to yourself or others? Why bother to take the risk of experiencing high levels of anxiety? Why risk experiencing the doubt and uncertainty that you feel might consume you? Because you deserve to have a better life than the one you have now with OCD.

OCD tells falsehoods and wants you to believe them. For example, it overestimates the potential for harm in a particular situation. Or, it tells you that, if you just do this one ritual or this brief avoidance, then the anxiety and stress will

go away. That's an OCD trap. While you very well might feel better for a brief time after ritualizing or avoiding, these behaviors actually strengthen the OCD thoughts and fears and make them even more potent the next time they arise. By listening to what the OCD is saying, you are teaching your mind and your body that the only way to make your fear/anxiety/doubt subside is to do what the OCD is telling you to do. However, the real solution for reducing and eliminating fear permanently is to experience and ride through the anxiety, fear and doubt, while trying to minimize and eliminate avoidance and rituals. By doing this you are teaching your mind and body that the anxiety/fear can come down on its own over time without the OCD's false help. This is not pleasant or easy; so try not to get down on yourself if you try to resist and don't always succeed. It's the determination and persistent effort to resist that are important.

So why keep fighting the OCD? Because the rituals don't work! Your OCD may trick you into thinking that rituals are helping by offering a small measure of immediate relief; but, beware of this. There are flaws and exaggerations in what the OCD is telling you. Consider the person who washes excessively to avoid getting a disease. This person's family members and friends don't wash as much and as often and they don't catch the feared disease. So, why bother doing all that extra washing anyway? Or consider the other side of the coin. You wash and wash and you still get sick. What have you really gained by spending all that time, energy and effort trying to prevent something that you really don't have control over? Take a risk; we live in a dirty world.

The following is another situation where your OCD is giving you false information. For a long time, you have been ritualistically repeating an activity because you had a bad thought while performing that activity and you are concerned that not repeating it or not getting it right will cause something bad to happen to a friend or family member. A bad thing happens to a family member anyway. Does this mean you weren't doing your rituals often or completely enough? Or, does it just mean that, unfortunately, in this world, there are times when bad things really do happen to good people? Ask yourself if you are overly concerned about the welfare of others. Why should you spend so much energy and time trying to protect them when the rituals don't work anyway? Things happen in this world over which we have no control. Often, even the very ones you are trying to protect don't feel it's necessary to take these steps. Ironically, in order to get control over your life, you have to give up the need for control and give up the feeling of being in control with respect to your OCD.

You may be saying: "I don't want to risk it" or "If my fears could happen, then it wouldn't be worth taking even a remote chance." Maybe the

OCD is telling you, "I can't put my own wants and needs before the health and safety of others" or "It's too unbearable to experience this doubt." Yet, look how much the OCD has cost you. How much has it kept you from enjoying activities with friends and family? How has it impacted the quality of the relationships you do have? Think of the time and energy (both physical and emotional energy) you have put into trying to make sure that the improbable will not happen. Look how your OCD has interfered with your career and the enjoyment of pleasant activities. Consider how much time you have spent pondering what the OCD is telling you in order to reduce the feeling of doubt. And, you're paying this price just to get some fleeting relief. You are entitled to more in life.

What do you wish for in life? You deserve to give yourself a chance to have it. When you are reflecting on your life, will you feel that it was worth putting off challenging your OCD to avoid feeling anxious for such a short time? Seize the opportunity now. Focus on getting through one day at a time. Push yourself to engage in even small "behavior therapy moments" as opportunities arise on a day-to-day basis. Take all the opportunities offered to you NOT to do what the OCD is telling you. Remind yourself that you don't have to eliminate the OCD all at once. You can get to the same level of OCD symptom reduction by working on one area at a time or by gradually choosing to wage lots of smaller OCD battles throughout the day. Remember that a journey is accomplished one step at a time. A willingness to experience short-term emotional discomfort is the path to symptom reduction. Daily persistence in chipping away at OCD symptoms is crucial.

A better quality of life is worth going after. The things in life worth pursuing occasionally require some level of hard work. No one else can do this for you; you need to be your own best advocate to bring satisfaction into your life. This involves going after as many of your compulsions over time as possible. At the same time, look at what you can do to practice exposure and response prevention tasks every day.

What contributes to quality of life? It's different for everyone. For some, it's the reward that comes with the enjoyment of each day's activities, whether these are rewarding solo activities or activities spent in the company of others at work or with family and friends. For others it's the feeling of accomplishing a task. OCD treatment is not just about symptom reduction. It's about getting back enjoyment in your life. Don't let the OCD keep you from pursuing what you want in life. Remember, no pain, no gain. You will need to experience the short-term emotional pain in order to experience the long term behavioral gain. No one else can do this for you. The determination needs to start with you. You didn't choose to have OCD, but you do have a choice in how you are going to respond to the obsessions. So, let go of the need to be in control, experience the doubt....the potential benefits in your life are worth it!

How I Treat OCD

(continued from page 9)

have touched or been touched by that person. The trigger event is the encounter with the person leaving the bathroom. The thought is, "I might have inadvertently touched that person and now I am contaminated and I am going to die." The emotional reaction and physical sensations are anxiety with rapid heartbeat, sweating, hyperventilation or panic attacks; and the behavior response is to go to a bathroom and wash one's hands.

The Treatment Plan and the Structural Model

The treatment planning guides the process of delivery of treatment. The treatments used are all outcome-based protocols; and, therefore, the interventions are defined and the timing of the delivery is specified. The therapist will decide which strategies and tactics to use to bring about the treatment goal. These concepts are defined as:

Goal = What will have to happen to achieve the desired outcome? What are the specific ways we will help the patient achieve the outcome in therapy?

Strategy = This is the selection of the specific therapeutic modalities which will best help the patient reach these goals. Most commonly, the strategy for treatment of OCD and comorbid anxiety disorders is the use of the cognitive behavioral model of treatment alone or in combination with medication. Because the treatment is time-limited and guided by a protocol of timing for the delivery of the interventions or tactics, a session-by-session structure is established. The implementation of this structure can have some flexibility depending on the patient's needs.

Tactics = This is the choice of the technical elements that will be used in the strategies. There are many tactics or cognitive and behavioral interventions that have been documented as being efficacious in treating OCD and the other anxiety disorders. Some of the specific tactics or interventions effective for the treatment of OCD are:

- * Exposure and Response Prevention (ERP)
- * Use of the Subjective Units of Distress Scale (SUDS) and the development of an exposure hierarchy
- * Modeling and in-session exposures with the use of props and/or *in vivo* exposures

Imaginal exposure

Anxiety management skills

- * Contingency management skills

Some of the interventions and tactics effective for the treatment of Social Phobia are:

- * Cognitive interventions
- * Identifying automatic thoughts and challenging thoughts
- * Use of the Subjective Units of Distress Scale (SUDS)
- * The development of an exposure hierarchy
- * Hypothesis testing
- * Exposure practices with the use of cognitive countering
- * Breathing retraining

Structure Of Treatment Sessions For Cognitive And Behavioral Therapies

Sessions 1-2

Conduct the assessment.

Do evaluation and history of the problem.

Document the frequency and intensity of symptoms with assessment instruments.

Reach agreement on treatment goals and specific interventions to achieve these goals.

Sessions 3-6

Deliver the rationale for treatment and teach the basic skills.

Discuss the cognitive and behavioral model of treatment. Establish a time frame for the treatment (3-6 months). Discuss the role of the therapist as a teacher and the role of the patient as learning to become her own best therapist. Set the expectation that the patient is learning skills to use for her lifetime management of these symptoms. Deliver the psychoeducational component of treatment, i.e., what is OCD? What is Panic Disorder? What is Social Phobia? What are the theories about the causes of these disorders and what is the cognitive behavioral theory and treatment rationale for these disorders?

Begin a functional analysis and identify trigger events and the symptoms. Start to teach the patient how to interrupt these symptoms with the specific interventions used for the treatment of the disorder.

Sessions 7-12

Modify the specific behavior or belief and practice skills.

Develop a hierarchy for exposures.

Develop a script for imaginal exposures.

Model and practice the key interventions, for example, exposure and response prevention, in the session.

Discuss the rationale for homework.

Motivate the patient to do the homework.

Assign homework.

Repeat the interventions guided by the hierarchy and homework.

Model and practice in sessions.

Sessions 8-12

Teach relapse prevention and discuss termination.

Teach about relapse prevention.

Discuss termination.

Repeat the interventions guided by the hierarchy and homework.

Model and practice in sessions.

Assign homework.

A Case Example

Diagnosis: Obsessive Compulsive Disorder, Social Phobia, Generalized Anxiety Disorder and Perfectionism

Harriet is a 26 old, white, single woman who is an insurance underwriter. Harriet presented for evaluation for treatment of Generalized Anxiety Disorder that is enhanced or intensified if there is a potential conflict, risk of losing face and/or possibility of rejection. She reports that she has had numerous difficulties with dealing with rejection, fear of failure, and potential conflict; and these difficulties have significantly impaired her ability to function at work or in relationships with men. She has attempted to date, but has been unable to have a permanent relationship. She is very anxious in her daily functioning. She often asks other people to help out. She states, "I ask people to make sure that I don't make a mistake." She overworks and is always striving "for perfection." She reports that the cost of this excessive anxiety is fatigue. She cannot settle on things. She is always taking on new projects, although she has difficulty getting started and finishing things.

Harriet fears failure and fears making a mistake. She states, "You have to be perfect all the time." When asked about what evidence she has to prove her failure, she really cannot find any evidence but cannot rationalize it away either. She has trouble opening her mail because she fears, "I'll be getting a letter that will say I did something terrible and it will hurt my career." She fears answering the phone and anticipates it could lead to conflict, i.e., she would learn about something that she did wrong or she would have to defend something she did. Although she can communicate well, she lacks assertiveness skills when she anticipates that she is going to have to defend herself or deal with conflict.

Harriet experiences anxiety, muscle tension, mental exhaustion, restless sleep, and somatic worries. She has Obsessive

(continued on page 12)

How I Treat OCD

(continued from page 11)

Compulsive Personality traits. She is scrupulous, has high moral standards and a need for things to be perfect. She cannot make a mistake. Her compulsive behaviors include checking, seeking reassurance, repeating, and procrastinating in order to avoid making a mistake. There is significant avoidance behavior, making of piles of things to do, and hoarding behavior. At her initial visit she was agitated. She had written notes so that she would not forget to tell me certain things. She stated, "I don't want to lose this train of thought." Her speech, at times, was hesitant. She became distressed if her train of thought was interrupted and, therefore, controlled the interview. She reported some feelings of loneliness and depression. Harriet had some insight into the fact that she seeks excessive reassurance. She expressed ambivalence about engaging in treatment and worried about finding the right person with the right treatment. At the end of the session, she had difficulty leaving.

Treatment

Harriet agreed to deal with her overall fears and concerns that focus on the fear of harm and humiliation, the fear of failure and the fear of performing. The target symptoms were handling the mail and worrying about what was going to be in it and dealing with phone calls and worrying about being humiliated or making a mistake. Behavioral interventions were focused on reducing her need for seeking reassurance and reducing avoidance behavior.

OCD: Worry about harm and perfectionism
 Trigger event - open mail. Thought - "I'll be getting a letter that will say I did something terrible and it will hurt my career."
 Behavior - avoid opening mail or get someone else to do it.

Key interventions used were cognitive behavioral interventions to address and challenge the belief, exposure practice of opening mail with hypothesis testing to address the probability of overestimation of harm. Exposure to the discomfort of the anxiety that arose and the use of response prevention for the avoidance behavior were also utilized.

Social Phobia: Worry - Fear of humiliation, fear of learning about a mistake, fear of failure, and fear of confrontation and conflict, as well as fear of rejection

Trigger event - telephone ringing. Thought - fear of answering the phone and anticipation that answering could lead to conflict, or that she would learn about something that she did wrong, or she would have to

defend something she did. Behavior - do not answer the phone.

Key interventions used were cognitive and behavioral interventions focused on fears of humiliation, fears of rejection and fears of confrontation. Exposure practices were planned for answering the telephone with hypothesis testing to address the overestimating of the probability of the feared fears happening. Assertiveness training was introduced to reduce fear of confrontation.

These key interventions were used until the anxiety was reduced and the beliefs were more rational and the behavior had changed. Harriet can now open her mail without the worry of something bad happening. She is able to answer the telephone and conduct business without the worry of making a mistake. Her ability to deal with conflict and confrontation is improving. However, she is still concerned about what other people will think of her if she expresses an opinion that is different from her co-workers. She continues to practice reducing her tendency to avoid or put off tasks that she fears she may not do perfectly.

Using a Strategic Pressure Approach



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When we think about treating OCD, we generally think of hope. We can think of no other disorder that can be so devastating and yet at the same time so treatable. At our centers, we often say that designing an E&RP treatment program is easy; obtaining compliance is an art.

The first part of an ideal treatment plan is obtaining compliance, i.e., convincing the sufferer to work at her treatment. This means deciding to learn to accept uncertainty that the feared consequences, no matter how unlikely, are possible. This acceptance is a prerequisite to following through with E&RP. If the sufferer doesn't want to learn to accept uncertainty, then s/he may be engaging in behavioral and/or mental rituals to "undo" the effect of the E&RP. This is not treatment. We spend a great deal of time preparing sufferers for treatment, because pressuring or forcing someone through a program who has not really agreed to do it is generally not helpful.

But what happens when the OCD sufferer cannot be convinced? If we cannot persuade the sufferer to participate, then both the therapist and the family concerned are helpless. What do we do about treatment refusers? There are a few options:

Option 1: Continue to attempt to persuade the individual with OCD to engage in therapy. This approach usually fails because we have already tried to persuade her and usually others have tried to persuade her, but with no success.

Option 2: Consider inpatient treatment.

Option 3: If someone continues to refuse treatment after we have spent a significant amount of time educating and persuading and if inpatient treatment is not an option or has failed, then the answer for the majority of the people in this group is to stop treatment and tell them to come back when they are ready. This is better than allowing them to go through treatment reluctantly or letting them undermine their own treatment. The result of such an outcome is that they leave therapy thinking, "I did the therapy and it didn't work," without them realizing that they didn't really do treatment. That message can be very damaging to a person. So we send many people away and hope that another therapist will be able to persuade them to really engage themselves in the therapy. Alternatively, we hope that the client's own suffering will eventually persuade her to participate in treatment at a later time.

Sometimes, to send these people away feels very WRONG. It feels wrong when the person is not functioning and the extent of her suffering suggests that this

situation will just continue indefinitely and possibly worsen. It feels wrong when a 13-year-old child cannot leave her home, is missing her childhood and she tells us that she will be housebound forever! It feels wrong when a person's rituals are causing severe medical problems that are potentially life threatening. It feels wrong when the person is 27 years old, has been housebound for 13 years because of his OCD, and, without intervention, there is no reason he won't sacrifice the rest of his life to OCD. In such cases, the sufferer is so caught up in the anxiety of OCD that he is too afraid to confront his fears, even though this is the only path to the different life he so desperately wants. Somehow, their horrible situation is just tolerable enough to make it seem easier than treatment. The reluctant sufferer's feeling is often that he has no choice – that his only option is to continue living with his obsessions and compulsions.

This brings us to an assumption that we make in the approach that we are advocating. Many people who are initially reluctant to participate in treatment will choose it when they realize they need to change to have the life they want. They go into treatment when they have hit "rock bottom." In other words, people typically choose to change when they have no choice but to change. But with the sufferers that we are referring to in this article, it is as if there is NO ROCK BOTTOM. Their OCD keeps getting worse and interfering more in their lives; and, yet they continue to refuse treatment. Our goal in this situation is to define a "rock bottom" for these people, rather than waiting for the OCD to totally disable them and reduce their lives to an endless cycle of nothing but obsessions and rituals before they agree to be treated. This is where Strategic Pressure is applied.

The consideration of using Strategic Pressure with the family comes long after repeated failed attempts at individual treatment. If the therapist is the sufferer's first stop for seeking therapeutic treatment and she refuses to engage in treatment, the therapist should initially try to persuade the patient to give the therapy a chance. If the client cannot be persuaded, then the therapist refers the individual to another therapist to see if she can be successfully treated elsewhere. Obviously, psychiatric evaluation and medication should be a part of the treatment. But if the individual is not progressing after repeated failed attempts or after a repeated series of partially successful attempts followed by profound relapse, at some point the question becomes: How many years will we do this before we need to try something else? It is at this juncture

that family therapy utilizing Strategic Pressure becomes a consideration.

There are a few caveats to using this type of treatment. The first is that this type of treatment has not yet been empirically researched. The treatment successes we have seen have been with a small sample of clients at our clinic in Bala Cynwyd, PA. The sample is small because it is a LAST RESORT treatment. We are in the process of starting a three-year project to evaluate Strategic Pressure; but, at this point, our program is based upon our clinical observations, not data. This treatment is akin to what would be done with an alcoholic or drug-addicted adolescent who is on a self-destructive course and cannot help him or herself. It should ONLY be utilized when the other options discussed above have been exhausted and when the individual's symptoms are severe and impairing or medically dangerous. This treatment does exactly what the therapeutic community typically says not to do. So, we are going against the popular wisdom.

Strategic Pressure is difficult. Although there are often challenges during the course of standard therapy, it is generally a positive experience because we are helping people who want change. In this approach, we are strategically pushing people to do what they do not want to do, with the ultimate goal of helping them.

There are a few rules before beginning this type of therapy:

1. This therapy can only be used with a child or adult/child who lives at home. It cannot be done with a spouse or an adult child who pays rent.
2. It is a variant of "tough love," but we think this approach is easier to do because it is not as severe.
3. Parents cannot do this on their own. There are many reasons for this. First, parents need to change how they react to their child. The old ways do not work. We are treating the family as much as we are treating the sufferer. They need to learn new ways to respond. Second, the approach requires a thorough knowledge of how to treat OCD in the subtlest of ways. Third, the approach requires an understanding of family systems and structures. Parents cannot tweak their own family structure or change their ways alone because they are in the middle of it.
4. As we stated before, this therapy is difficult. Therefore, before starting the treatment, the family must be ready to change. The goal of using a Strategic Pressure approach is to promote success. We want to help someone improve who is so restricted by anxiety that he or she is not

willing to make this choice on his/her own. We are cornering the individual so that the path of least anxiety is to choose to do treatment. The strategic part of the therapy is to set things up to encourage the sufferer into a higher level of treatment, with the ultimate goal being his/her willing participation in CBT.

When we are successful, family therapy using Strategic Pressure consists of four phases of treatment. In Phase One, the sufferer's family is the client and the OCD sufferer refuses to attend sessions. The reason for the family going into therapy is explained to the sufferer as follows: We are starting treatment whether or not you want to engage in treatment. You can choose to participate or not. If you choose to participate, then you will have some control over the treatment choices made and the steps of treatment. If you do not choose to participate, all choices will be made for you. By working with the family as the client, we are able to do what cannot be done when working directly with the sufferer.

The crux of the treatment approach is creating a hierarchy of symptoms. Because the OCD sufferer is not initially a willing participant, the therapist, using reports from the family, creates an exposure hierarchy for the OCD sufferer. We try to make steps small enough so that they are doable.

Movement occurs through use of forced choices. The sufferer will need to do something, or else something that is slightly more anxiety-producing will be done for him/her. We are using the sufferer's anxiety to motivate him/her. The ideal is to "pressure" the sufferer with exposure to items that are higher on his/her hierarchy to do a task that is lower on the hierarchal scale. For example, for a sufferer with contamination obsessions, a choice might be: "You have to touch all the doorknobs in the house; or this rag that has touched the floor will be spread throughout the house so that you cannot avoid the contamination." Although, as a first step, this would probably be too demanding.

Phase Two is when the OCD sufferer joins the family in therapy and then is able to exert some influence over treatment steps. The nuts and bolts of the second phase are very similar to Phase One. What is different about Phase Two is that "family contracting" is introduced. That is, the situation becomes more flexible: there is room for negotiation as long as the negotiation occurs during a therapy session. If the sufferer objects to a step of treatment that is proposed during the session, then he is allowed to offer a reasonable alternative that will accomplish something of

From The Foundation

(continued from page 1)

Bethesda, MD, in January to meet with Dr. Insel and some of his staff, including Dr. Susan Swedo whose had done so much groundbreaking work in the area of OCD in children. After talking about what the Foundation was doing and the state of OCD research, Dr. Jenike, always shy and retiring, asked Dr. Insel to be our keynote speaker. He agreed. I think he was relieved that Dr. Jenike was just asking him to give a speech and not challenging him to one of his infamous one-on-one basketball games.

Dr. Insel's topic is "Mental Health Research in the Genomic Age," an incredibly relevant subject now that many researchers in the field are investigating whether or not OCD has a genetic link. Dr. David Pauls, from Harvard Medical School, the organizer of the OCF Genetics Collaborative, will also be at the Conference to give an update on the research being done by the members of the OCF Genetics Collaborative.

Our challenge this year was to make the 11th Annual Conference attractive not only to people who were just learning about OCD, but also to those of you who have been to previous Conferences. We utilized some advice from the kids who attended our Young Leaders meeting at last year's Conference. They told us that they knew what obsessions and compulsions were. They didn't need speakers to stand up in front of them and define them. They lived with them. What they wanted were techniques to deal with them and information about the medications available so that they could start to control their OCD instead of their OCD controlling them.

This was some of the best advice we had gotten on designing a Conference; and, it was free. Not only did we use it in selecting presentations for teens and young adults, but we also used these concepts as criteria for the whole program. In our "Call for Presentations," we described the types of workshops and presentations that our young leaders said they wanted: interactive sessions demonstrating treatment techniques; "Q & A" sessions on medications, side effects, and augmentation therapies; and seminars where people with OCD share their experiences managing specific symptoms. We asked presenters to

design workshops on specific symptoms and the exposure and response prevention activities that could be used to eliminate them. We told them that family members wanted to learn about their role in helping the person with OCD and treatment providers wanted to learn treatments that worked.

The suggestions our young people made struck a chord with the people who submitted proposals this year. They responded with sessions that met the demands and we based our selections on these criteria. To start with, there will be different tracks at the 11th Annual Conference: tracks for individuals with OCD, for parents and family members, for treatment providers, for adolescents and young adults and for kids with OCD. In the symptom specific category, there will be "You're Going to Ask Me To Do What," a workshop on contamination OCD; "Damned If You Do, Damned If You Don't: The Scrupulosity Bind," Intrusive, Violent and Sexual Thoughts, Scrupulosity and Perfectionism," and "Obsessing About Obsessing: The Cruellest Obsession."

We have presentations on how to treat specific OCD symptoms. Dr. Wiegartz from the University of Illinois at Chicago is talking about "Diagnostic Strategies in OCD: The Importance of Assessment in Treatment Planning." Other sessions on treatment include "Refractory Aspects in the Treatment of Obsessive Compulsive Disorder," "Pharmacological Treatment of Children with OCD," and "Issues in the Identification and Treatment of Treatment-Resistant OCD and Spectrum Disorders: A Clinical Roundtable."

For individuals with OCD who want to learn to manage their symptoms, there's the workshop on G.O.A.L. groups and the annual G.O.A.L. Camping Trip on Friday night, "Cognitive Behavior Therapy for OCD: An Open Forum for Questions and Answers," and Dr. Jeffrey Schwartz's talk on "Progressive Mindfulness IV." There are interactive sessions on "Journaling Therapy" and "People Jitters and Fears: A Workshop on Co-Occurring OCD and Social Phobia," along with a panel discussion, "Patients' and a Therapist's Perspectives: Obstacles and

Challenges in Intensive Treatment for Severe OCD."

For the adolescents and young adults who inspired the programming for this Conference, there are seminars and workshops specifically tailored to their requests. Starting out on Friday, is a forum for them, "Ten 'Killer Questions' About OCD and the Answers Teens Have Been Looking For," asked and answered by Drs. Grayson and Mansueto. Dr. Penzel is going to help them take on horrific thoughts in "Those Rotten, Ugly, Nasty Thoughts: A Teen Forum." Dr. Fitzgibbons and some of the therapists from the Agoraphobia and Anxiety Treatment Center are going to help teens with OCD get through adolescence in the workshop, "It Ain't Easy: Teens with OCD." There are other sessions just for them as well as a hospitality suite where they can do art projects, play games or just chill out with one another. There will also be a workshop on choosing a career, "Finding the Right Career Fit" and a "Young Adults Discussion Panel."

For the kids (ages 6 to 13), there's their own Hospitality Room where an art therapist will help them create OCD-related art. There are also sessions just for them, including, among others: "Lights, Camera, Action! Beat the Brain Bug," "Take It From Me...You Can Beat OCD," two "Kids G.O.A.L. and Play Groups" and a session on beating OCD lead by Dr. Renae Reinardy, entitled "Smackin' Down OCD," and an explanation of "Why You Do The Things You Do - Basic Facts About OCD" by Lori Kasmen, Psy.D. and Kathleen Rupertus, MA, MS.

Parents will be able to attend sessions that address their problems, including two sessions by Mary Kathleen Norris, "Untangling Behaviors in Kids" and "I Need Tools Now!" on dealing effectively with children with OCD. There will also be a "Parent and Clinician Forum," a session on "IEPs: A Blueprint for Parents," as well as Dr. Jerome Bubrick's presentation on "Getting Your Child to the Starting Line: Parents' Roles in Obtaining and Monitoring Proper Treatment," along with sessions on medication for children and CBT for pediatric OCD. These and other sessions, not only provide parents with the information they need to manage their child's OCD, but they give them a chance to meet each other and share their experiences.

"The Forgotten Sufferers - The Family"

How I Treat OCD

(continued from page 13)

will shine some light on the role the family plays in treating OCD. Among the other presentations for family members are: "Families and OCD: Compatible or Combustible," and "Treating the Family When the Sufferer Refuses Treatment." At the request of the Young Leaders, we have even added a session for siblings.

Altogether there are over 70 sessions, workshops and support groups, including Dr. Jenike's two-hour "Question and Answer" session. We've saved it until Sunday morning to give people an incentive to get up the morning after Saturday Night's Reception. We think we have presentations to interest everyone who attends.

The Art Exhibit this year will feature not only works by people affected by OCD but also by a group of Chicago-based artists. We have filled (some have even suggested that we have crowded) the weekend with activities that we hope will keep everyone, the OCD sufferer, and family members and loved ones and treatment providers, almost too busy to enjoy all the excitement that downtown Chicago has to offer, which is considerable. OCF past president Janet Emmerman outlined all the activities and special attractions Chicago has to offer in her column in the Winter 2004 issue of the OCD Newsletter, as well as cataloging all the great shopping right down the street from the hotel on the "Magnificent Mile." For attendees who don't want to miss anything at the Conference, our hotel, the Hyatt Regency Hotel on the River Walk, will extend the OCF special rate for three days before and three days after the Conference. This way you can participate in every session you're interested in at the Conference and still get to sample all the activities and attractions that make Chicago such an exciting place.

To register for the Conference, fill out the Registration Form in the Registration Brochure that was mailed to you or go on-line to our website, www.ocfoundation.org and download the form there or register on-line. If you have any questions or want more information, call us at 203-401 2070 and press any extension. All of us here at the Foundation's offices are really excited about the 11th Annual OCF Conference and ready, willing and able to get you any information you might need.

Ciao!

Patricia Perkins

similar value. There is no negotiation or bargaining outside of session in order to keep things predictable for the sufferer and to help the family prevent enabling, which just feeds the OCD.

Phases One and Two are often very difficult for everyone. Parents are having to hold the line more firmly than they might like. The consistent message to the sufferer is: we are committed to doing whatever is necessary to block and fight your OCD until you are able to fight for yourself. This sometimes means locks on doors or cabinets and other means of providing barriers to OCD rituals. During Phase Two the sufferer may express great dislike for the process. When this occurs, the therapist commiserates with the client. If only the sufferer would agree to do "ideal" individual treatment, then this process would not be necessary. If only he felt able to fight for himself, then the family would not have to block the rituals and compulsions for him. The sufferer is reminded that if s/he were to actually DO treatment independently of the family and the family were to see progress, then eventually, the family might be able to bow out of the process. In such a way, the bait for individual therapy and "ideal treatment" is laid. As the process of Phase Two continues, the frustration and lack of control the sufferer has over treatment encourages him to decide to enter individual treatment on his own.

Phase Three of the treatment begins when the sufferer opts to work with his/her own therapist on the OCD and the family continues to work with the family therapist. The family therapist becomes the "Bad Cop," who sets deadlines for major improvements rather than determining weekly E&RP exercises. The family therapist also continues to use forced choices to determine the consequences if deadlines are not met. Deadlines are important to prevent individual therapy from degenerating into a process where the steps the individual therapist can achieve with the sufferer are so small that they are not meaningful. The "Good Cop" is the individual therapist who helps the sufferer establish weekly E&RP goals so that s/he can progress to the larger deadlines without suffering the anxiety that will be engendered by the designated consequence. The individual therapist provides the support, encouragement, guidance and exercises that the sufferer needs to do the work. The family therapist is keeping the pressure on while the individual

therapist gets the work of E&RP done.

Phase Four of treatment is usually a natural evolution from Phase Three. As the person begins to succeed, the pressure exerted by the family therapist can be slowly withdrawn while the influence of the sufferer's therapist increases. The sufferer has begun to do "ideal treatment" by becoming a willing participant in CBT. He or she is no longer a treatment refuser: the ultimate goal of the Strategic Pressure approach has been met. Family members may continue to work with the family therapist to ensure that they are appropriately supportive and encouraging without enabling the OCD.

As we stated at the beginning of this article, we believe that treatment for OCD is about hope. OCD is a treatable disorder. Although it is a last resort approach and a difficult process, the family therapy approach utilizing Strategic Pressure is also about hope. It provides hope for therapists who previously had to turn treatment refusers away to suffer with OCD until they were "ready." It provides hope for the families by providing a way that families can take action and fight back against OCD for their loved one rather than standing back and watching their loved one continue to suffer. Finally, we believe this approach gives hope to sufferers, often considered "untreatable" or "not ready" for treatment, who otherwise might have chosen to live many more years bound by OCD.



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