OCF Obsessive Compulsive Foundation

OCD Newsletter

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Scrupulosity: Blackmailed by OCD in the Name of God

By Laurie Krauth, MA

"I pass by a picture of my kids and think, Satan: they are my gift to you," my new client John, a wonderful husband, father of three and successful businessman tells me. "Why would I think that? I would never sell my soul to the devil." On another day, he says in shame, "We are cutting shapes out of construction paper at the table and I'm thinking the devil will make me lose control... In church, finally, I'm feeling hope and then I think maybe God wants me to harm someone. I would never sell my soul; that is the last thing God would want."

I don't recoil in horror, as he does, because many other good, moral clients have told me about their own nightmarish thoughts. A chaste Christian college freshman obsesses that his "wild" close dancing with a girl is "bad" and fails the "What would Jesus do?" test. He repeatedly replays the dance scene in his mind, hoping to reassure himself that he didn't give her false hope that he would sleep with her. A Catholic nine-year-old girl obsesses that she once spelled "God" without capitalizing it and avoids stepping on floor stains that look like Jesus. When she passed a math test she wasn't prepared for, she worried endlessly that she cheated, and prayed to God repetitively for forgiveness.

Sufferers of scrupulosity around the world share their own versions of my clients' nightmarish thoughts. They have persistent, irrational, unwanted beliefs and thoughts about not being devout or moral enough, despite all evidence to the contrary. They believe they have or will sin, disappoint God, or be punished for failing. In response to their disturbing thoughts, they try to calm themselves using a host of compulsions. Some repeat religious phrases; others call their pastors for reassurance; many avoid situations – even going to their beloved church or temple – because they trigger their horrible obsessive thoughts.

Documentation of people with this form of Obsessive Compulsive Disorder goes back centuries. The 16th Century theologian Martin Luther was tormented by urges to curse God and Jesus (Baer, 2001). When he

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OCF Gives Support to Genetics Studies

Joy Kant, President of the board of directors of the OCF presents Dr. David Pauls of Harvard with a check for $100,000 to use to further his genetics work. Evelyn Steward, M.D., who works with Dr. Pauls, is at right. Dr. Pauls is the chairman of the OCF Genetics Collaborative.

Dr. Gerry Nestadt of Johns Hopkins is being given a check for $100,000 by Joy Kant and Thomas Lamberti, esq., Vice President of the OCF Board of Directors. Dr. Nestadt is a member of the OCFGC. These grants were funded by contributors to the OCF Genetics Fund and the McIngvale Family.

(See Genetics Collaborative story on page 12)

Message From the President

Dear Friends,

During last summer's Obsessive Compulsive Foundation Annual Conference in Atlanta, Georgia, many of you expressed an interest in participating in efforts to help pass better mental health parity legislation. At the meeting, I promised to let attendees know how we could play a role. The following summary describes the Congressional activity currently underway.

The original parity law, the Mental Health Parity Act of 1996, provided only general rules regarding annual and lifetime dollar limits on coverage for mental health care compared with medical and surgical benefits coverage. New legislation was introduced in 2001 to provide a more comprehensive framework for mental health coverage parity with coverage for medical and surgical benefits. The goal of the legislation was to guarantee that the 53 million Americans suffering from mental illness and the 26 million Americans suffering from chemical addictions have access to effective treatment.

The bill, called the "Paul Wellstone Mental Health and Addiction Treatment Equity Act" after the late Senator who championed the cause, would expand the 1996 law by requiring group health plans to offer benefits for mental health and addiction on the same terms (co-payments, limits on number of visits, etc.) as care for other diseases.

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Bulletin Board

Appearance Concerns Medication Research Study

Are you worried about the way any part(s) of your body (for example, your skin, hair, nose, eyes) look?

Do you think about your appearance for more than one hour per day?

Do these thoughts upset you?

Do you have problems with your school, family, or friends because of your worries?

Do you wish you could do something about this problem?

IF YOU ARE A CHILD OR TEENAGER (age 16 and younger) and answered "yes" to any of these questions, you might be eligible to participate in a study at the Massachusetts General Hospital (MGH). If you qualify, you will receive the following:

Diagnostic Evaluation
Study Medication

You will also be asked to fill out some questionnaires assessing body image symptoms, anxiety and mood. Participation in the study will be at no cost to you.
If you are interested in participating, or would like to get further information, please call the Body Dysmorphic Disorder Clinic at the Massachusetts General Hospital (MGH) at (617) 643-3079 or email BDD@partners.org.

Research Volunteers Needed!

Have you been diagnosed with Obsessive Compulsive Disorder?

Do you experience symptoms such as persistent, unwelcome thoughts or images, or the urgent need to engage in certain rituals like repetitive hand washing, counting, checking, or cleaning even though you have been treated with medications?

If so, you might qualify to participate in a research study!!

To be eligible, you must also:

- Be at least 19 years old
- Be willing and able to come to the clinic weekly for 14 weeks

We offer:

$25 per visit for time and travel

Physical examination, EKG, laboratory work-up, and study medication at no cost to you.

If you are interested in participating in this research study, please call The Psychiatry Research Center at 402-660-2903 or Angie at 402-345-8828 x 24
Creighton University
Department of Psychiatry
3528 Dodge Street
Omaha, NE 68131

Acamprosate (Campral) for SSRI resistant Obsessive Compulsive Disorder

Principal Investigator: Sriram Ramaswamy, MD
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The selective serotonin reuptake inhibitors (SSRI) are usually the first line of treatment for Obsessive Compulsive Disorder. However, treatment resistance to SSRI's (Prozac, Zoloft, Paxil, Celexa, and Lexapro) is quite common and a major clinical problem. Our aim is to study the efficacy and safety of adjunctive acamprosate (Campral) in SSRI-resistant OCD. Acamprosate (Campral) is approved by the FDA, but not for the treatment of OCD. The study will involve weekly visits for 12 weeks and participants will get free medical care, study drug and a $25 stipend for each completed visit.

If you are interested in participating in the study, or finding out more about it, please call the Creighton Psychiatry Research Center at 402-660-2903 or visit our posting on careerlink.com (http://omaha.careerlink.com/3/3/0/8/po/000001f.htm).

Intensive CBT Training Workshops for Professionals

Cape Cod Institute, 2007
Presented by Aureen Pinto Wagner, Ph.D.
July 30 through August 3, 2007:
Cognitive-Behavioral Therapy for OCD and Anxiety: Effective and User-Friendly Treatment for Children and Adolescents. This workshop is designed for clinicians and school personnel with beginner to intermediate experience in CBT. The focus is on the application of empirically-sound, developmentally sensitive and appealing CBT approaches that are feasible in clinical settings and designed to optimize motivation and treatment compliance in youngsters. Opportunities for learning will be maximized through clinical vignettes, video-taped demonstrations, case discussions, Teaching Tools and detailed handouts. Strategies for building treatment-readiness, collaborating with parents, managing anxiety in school, working with reluctant children, relapse prevention, and challenges in treatment will be discussed.

August 6 through 10, 2007: **Cognitive-Behavioral Therapy for OCD and Anxiety: Complexities and Challenges in Treating Children and Adolescents.** In

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OCD NEWSLETTER

The OCD Newsletter is published six times a year.

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The Obsessive Compulsive Foundation (OCF) is a not-for-profit organization. Its mission is to increase research into, treatment for and understanding of Obsessive Compulsive Disorder (OCD). In addition to its bi-monthly newsletter, the OCF's resources and activities include: an annual membership conference, web site, training programs for mental health professionals, annual research awards, affiliates, and support groups throughout the United States and Canada. The OCF also sends out Info Packets and Referral Lists to people with OCD, and sells books and pamphlets through the OCF bookstore.

Paroxetine and Birth Defects

By Paul Cannistraro, M.D.
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Massachusetts General Hospital

It can be quite frightening when we hear new reports of side effects or adverse reactions to a medication, particularly when a drug is linked to an increased risk for birth defects. While mood stabilizers such as Lithium, Depakote, and Tegretol have long been associated with congenital defects, the same could not be said with regard to the SSRIs. Studies of thousands of pregnant women over the past decade had failed to show any persuasive evidence of an increased risk for birth defects in infants exposed to SSRIs during the first trimester. However, that has now changed, at least for one SSRI.

In December 2005, the US Food and Drug Administration (FDA) warned healthcare professionals and patients that exposure to paroxetine (Paxil) during the first trimester of pregnancy might increase the risk for congenital birth defects. The alert came in response to data that had been recently collected in both Sweden and the U.S. One report, based on data from the Swedish national registry, found cardiac defects in 2% of the 822 babies who had been exposed to paroxetine, compared with 1% in the general population. Another study, which analyzed information from a U.S. insurance claims database, found that cardiac defects occurred in 1.5% of infants exposed to paroxetine, compared with 1% of infants exposed to other antidepressants in utero. Glaxo, the makers of Paxil, looked at data from more than 3,500 pregnant women taking antidepressants. They found that 4% of infants exposed to paroxetine were born with birth defects of any kind, compared with 2% of infants whose mothers had been taking other antidepressants. By point of comparison, in the general population, the chance of having a baby with a birth defect is 3%.

These findings were all inconsistent with previous studies which had failed to demonstrate any increased risk for congenital defects associated with paroxetine. At the request of the FDA, the pregnancy category of paroxetine was changed from C to D. The latter category is reserved for drugs which have demonstrated a risk to the fetus, but also a therapeutic benefit which might outweigh that risk.

The primary risk of stopping any psychiatric medication is a relapse of the condition which was being treated. There is much evidence showing that depression and anxiety in the mother may have an adverse effect on the infant. It is often quite difficult for people with active symptoms of mental illness to take good care of themselves. For an expectant mother, that might mean missed pre-natal appointments, poor eating habits, or even drug and alcohol use.

If you are not presently taking an SSRI but your doctor is now recommending that you start one, then you should have a discussion with your doctor about which one to take. If you are planning a pregnancy or especially if you are already in the first trimester, then it would be advisable to favor one of the older SSRIs such as fluoxetine and citalopram which have been extensively studied and have not been shown to pose any risk for congenital defects.

For those women who are currently demonstrating a therapeutic response to paroxetine, it is also very important to note that they might not have the same degree of response with another SSRI. Therefore, one might very well have the same experience in switching from paroxetine to fluoxetine or citalopram as they would have had they simply stopped taking medication altogether.

Thus, the decision to stay on paroxetine during pregnancy might be wrong for one person, but right for another. Therefore, it is vital to discuss with your doctor the risks associated with taking paroxetine during pregnancy, as compared to the risks of stopping paroxetine.

National Anxiety & Depression Awareness Week May 6-12, 2007

Obsessive Compulsive Foundation Needs Your Help...Free Promotional Gift

Anxiety and Depression can happen to anyone, at any age, at any time. Unfortunately, each year more than 35 million Americans will suffer with an anxiety disorder (Generalized Anxiety Disorder, Obsessive Compulsive Disorder, Panic Disorder, Posttraumatic Stress Disorder and Social Anxiety Disorder) or depressive illness (Major Depression, Bipolar Disorder and Dysthymia). However, when diagnosed these medical illness can usually be effectively treated. **The Obsessive Compulsive Foundation is proud to be a sponsor of National Anxiety & Depression Awareness Week May 6-12, 2007.** We are inviting all interested individuals to participate by helping to promote awareness of the event to the public. Hopefully this will be an opportunity for many suffering individuals to find help. If you wish to have a professionally designed poster about the signs and symptoms of anxiety disorders and depression, one will be mailed to you free of charge. We are particularly interested in displaying posters in places such as libraries, supermarkets, offices, hospitals, doctors offices, schools, colleges, and similar places. To receive a poster, please request one at help@freedomfromfear.org or fax: 718-980-5022. Please include your name, mailing address including zip code and phone number. If the poster is to be mailed to an organization, please state its name and that of the contact person.

Support Groups are Vital in OCD Recovery

On Tuesday, February 27, 2007, the Hudson Valley OCD Support Group celebrated the group's ten plus years of healthy existence with a dinner and social at Marist College, Poughkeepsie, NY. Eighteen members enjoyed the culinary delights of the Sedexho Food Service and dined in the President's private dining room at Marist College.

Picture in the first row are the current co-facilitators, John George, Ph.D., Chris Vertullo, and Christine Young, PsyD. In the second row are Maureen R., Loraine K., Chris H., Gerie D., and Mike G. In the back row are Joan M., Hutch H., Les B., Linda K., Matt C., and Kim G. Dr. George has been a co-facilitator of the support group since its inception and Dr. Young has co-facilitated the group since 2001. Both psychologists maintain private practices in Dutchess County and treat individuals with OCD. For contact information about the group go to www.ocfoundation.org and click on Support Groups.

The group's first meeting was on July 9, 1996 and has met twice a month since that day. Currently the group meets at St. Francis Hospital in Poughkeepsie. Although no one ever counted how many individuals with OCD and their families attended the group, founder Chris Vertullo estimates more than 300 people have shared their OCD tales and success stories over the years. This support group owes its success to talented leadership but more importantly to brave individuals who dare to walk into a support group, admit the control OCD has over their lives and then listen to others who truly understand how they feel. The seasoned members help the newer ones label their behaviors as OCD and their presence gives the newcomers hope that they too can win the OCD battle. Individuals with OCD who come to support groups are very courageous people and when they learn to control their OCD, they are the best medicine and teachers for the newer members of the group. Support groups are vital in OCD recovery, and watching the cycle of current members helping new ones is very rewarding for everyone in the group including the professionals.

Scrupulosity: Blackmailed by OCD in the Name of God

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prayed, the religious leader was obsessed with images of "the devil's behind." St. Ignatius, the 16th Century Portuguese Jesuit, couldn't step on two pieces of straw if they formed a cross because it would show disrespect to Christ on the cross.

Studies show that scrupulosity is the fifth most common form of OCD after contamination, aggressive thoughts, symmetry, and somatic concerns (Foa, et al, 1995). Today, scrupulous Catholics, born-again Protestants, Hindus, and others post anguished questions about their obsessions and compulsions on the internet listserv, The Scrupe Group.

Some studies suggest that scrupulosity is more common among people who are especially devout, or whose religions have certain tenets, such as emphasizing "perfect" devotion or considering bad thoughts as sinful as bad deeds. Nevertheless, it affects people from multiple religions whose level of devotion varies, and even affects atheists.

Scrupulosity versus healthy moral and religious belief

If you have an occasional irrational, unwanted thought, do you have OCD? Everyone has such thoughts. People without OCD just dismiss them as unimportant and move on. If you are committed to your religion, morality, or ethics and want to be as good as you can be, is this scrupulosity? Many devout and good people feel this way, and continually demand more of themselves. People without OCD may try harder when they feel guilt or disappointment about something they think or do. But they are not obsessed with their failure.

OCD sufferers, on the other hand, dramatically overreact to perceived failures. They "see sin where there is none" (Nelson, Abramowitz, Whiteside and Deacon, 2006) or blame themselves for falling short of impossibly high standards. They are tortured by the intensity of their doubts about whether they are good or not and so they find themselves believing the OCD voices that tell them they are downright bad.

Their discomfort helps make it hard to dismiss the thoughts, which become sticky and hard to chase away. The persistence of the thoughts and the frequency and anxious intensity with which they return turn those irrational thoughts into obsessions.

Think of the obsession as a mosquito bite – it's unwanted, uncomfortable, and feels like it will never go away. In response, OCD sufferers feel they must get rid of that obsession at any cost. The result is a compulsion, and it's much like the scratching of a mosquito bite.

To neutralize those disturbing thoughts, sufferers often use a mental or physical ritual, such as repeating a religious phrase or religious act, seeking reassurance, or doing penance. The obsession may be temporarily relieved by the compulsion; but it soon returns, more powerful than ever, just like a mosquito bite itches more after scratching it than if it is left to itch for awhile.

John, my former client, obsessed about having sold his soul to the devil in exchange for his wonderful life, and then compulsively repeated religious homilies for hours. Finally he would repeat to himself: "I am a good Christian man. I am a good Christian man."

Phillipson & Schwartz (2006) suggest that some sufferers become preoccupied with a trivial part of the religious ritual instead of the whole picture. For instance, they may focus on saying prayers perfectly instead of developing a relationship with God. They may act "more Catholic than the Pope" (for example, if confessing weekly is normal, going daily).

OCD rituals differ from devout religious practice, but it can be hard to tell the difference at first glance. In fact, many religions have behaviors that may look to the outsider like OCD. For example, Jennifer Traig, the author of a wry memoir, "Devil in the Details: scenes from an obsessive girlhood," describes the ways Orthodox Jewish religious rituals and scrupulosity compulsions may be mistakenly confused with each other: "Judaism has codified a whole choreography of compulsive, compulsory gestures and tics," the scrupulosity sufferer writes. "We reach up to touch the mezuzah each time we pass a doorway. We kiss the prayer book when we close it, the Torah when we approach it, any religious object when we drop it. We cover our eyes when we say the Shema prayer, and bend, bow, and straighten when we say the Aleinu. Orthodox Judaism looks so much like scrupulosity that some psychiatrists, and my father, have asked if they might be one and the same," she teases.

"[But] there are some vital differences. Orthodox Jews are motivated by spiritual duty and rewarded by a sense of fulfillment; the scrupulous are motivated by [brain] circuitry and rewarded by chapped hands. Most scrupulous Jews tend to overlook, even violate, the bulk of the laws while observing one or two with excruciating care. Compulsions tend to come before commandments. I could violate three or four commandments in one fell swoop. I was happy to lie to my dishonored parents while breaking the Sabbath, as long as it was in the service of getting my hands ritually clean." (Traig, 2004, pp. 33-35)

Despite many rules governing life, Judaism, in fact, does not seek perfection. For instance, Orthodox Jews don't mix meat and dairy products in the same meals. But under the principle of K'zayit, they needn't worry if a drop of milk touches their meat. Likewise, "the ideal is to totally concentrate on the prayer in a perfect communion with God. [But the principle of] B'dieved, which roughly translates to second best, says that if your mind wanders while praying, keep going and don't repeat the prayer" (Grayson, 2006, p. 224).

Examples of other religions with beliefs and practices that can be mistaken for scrupulosity abound. But the anguished obsessions and compulsions, the tormenting doubt and guilt, distinguish scrupulosity sufferers from morally and religiously inspired people.

What causes scrupulosity?

Religion itself doesn't cause scrupulosity, of course; it's merely the form some people's OCD takes. OCD has an extraordinary ability to target sufferers' Achilles' heel, attacking people where they're most vulnerable. OCD sufferers are thought to have an "ambivalent sense of self." For example, if their core belief is that they are bad, they'll listen more to the thoughts that "prove" that to themselves, dismissing the evidence that they are, in fact, good (Wilhelm & Steketee, 2006). Although John was a devoted family man, he gave far more weight to the bad and certainly irrational thoughts he had about harming his loved ones.

Presently, researchers believe that OCD is genetic, passed down through families. People with a biological predisposition for OCD will develop it at some point, triggered by an event, experience or environmental stressor. But even without that particular incident, they would eventually develop it because of some stressful experience.

John recalled that his OCD began at the age of seven. A teacher at his Catholic school talked about a man who sold his soul to the devil for riches. That comment triggered a fear that he had done it as well. He responded with hand washing and checking symptoms to reduce his anxiety, but he continued to suffer throughout his childhood.

Finally, in high school a psychiatrist diagnosed him with depression and prescribed

Prozac, which can also reduce OCD symptoms. He took Prozac through his early 20s, when he decided he no longer needed it. His OCD symptoms ebbed and flowed for the next decade. He came to me 25 years after his OCD had begun, when he was sagging under his work stress. After a colleague told him she'd had an encounter with the devil, John became obsessional and suicidal.

When he began treatment with me, he said he wondered if his phenomenal success now – wonderful kids, wife and career – was evidence that he did sell his soul and that he would go to hell. Irrational thoughts appeared at agonizing moments.

"I'd be bathing the kids and have the thought that I wished the devil would make me hold them under water," he said. "Or I'd be wrestling with the kids [and imagine] grabbing their throats and saying that I will sell my soul to strangle them, or putting them to sleep and hoping Satan will make me smother them with a pillow."

He repeatedly had blasphemous thoughts. He'd think, "Come to me Lucifer," and repeat to himself in horror, "You cannot take my soul. God protect me. Jesus is Lord." Or he would say, "I'm going to harm my kids. Satan, they're my gift to you." His compulsion was to repeat: "Satan, you are not my Lord. I'm a Christian man."

At the same time, hoping to quell the severe anxiety that the irrational thoughts gave him, he might use a "safety behavior," such as getting away from them. He started to turn bathing them over to his wife, and refused to be near his children with a knife or a pizza cutter, both of which he'd imagined using to murder them.

John was naturally horrified by these thoughts and the fact that they occurred to him at all seemed proof that he had sold his soul to the devil.

Treatment: Cognitive-Behavioral Therapy

John wanted to fight back to regain his family and himself. In his reading, he learned that numerous studies showed cognitive-behavioral therapy (CBT) was highly effective in beating back OCD. But choosing to begin treatment was still a scary decision. The stakes seemed so high for him and for his loved ones. What if his thought that he had sold his soul to the devil was true and he stopped trying to win his soul back? He might go to hell. What if he was right that thinking about harming his family made him more likely to do it? Then if he didn't avoid potentially dangerous situations with them, he was risking their lives.

Yet the wise part of him knew that those obsessions came from OCD and were not true. To begin treatment and defy his OCD, he needed the courage to trust his "wise mind," as Wilhelm and Steketee (2006) call it.

People with OCD crave a certainty that isn't possible. They want a guarantee that awful things won't happen. What's particularly challenging about scrupulosity is that it's virtually impossible to logically disprove. If you believe you'll go to hell for thinking about sex with the Virgin Mary during Mass or not saying your prayers "perfectly," only death will provide you with the evidence. And with what feels like such high stakes – in this life and after – standing up to the OCD seems especially risky. John took a leap of faith in harnessing his wise mind to enter treatment.

Like other CBT therapists, I use two primary tools. One is cognitive therapy, which challenges the thinking errors common to OCD. The other is a behavioral treatment called exposure and response prevention (ERP). With ERP, John actively encouraged those nightmarish, irrational, anxiety-producing thoughts and behaviors while refusing to use rituals to chase the anxiety away. until his anxiety diminished on its own.

Clergy can help prepare and support their parishioners in this therapeutic work. I would never ask clients to do something that they truly believed would violate their religious beliefs. But sometimes scrupulosity sufferers can resolve those concerns by meeting with clergy who are educated about OCD.

A religious leader can emphasize that perfection isn't necessary to express faith and help sufferers separate out their OCD from their devotion to God. It's also very helpful for sufferers to hear from their clergy that they are not sinning when they do exposure exercises in which they say or do things that feel unpardonable to them.

Sometimes it is helpful for a clinician to meet with a client and clergy member together, especially if the religious leader is unfamiliar with scrupulosity. (In presentations to clergy, I've found that many initially think they have never seen it in their congregants. But eventually most recall parishioners who, in fact, might suffer from scrupulosity – an infirm widow who must polish the silver daily whether it needs it or not or a young man who calls repeatedly for reassurance that any number of thoughts or deeds aren't sinful.)

Cognitive Therapy

John exhibited a number of classic thinking errors common to people with OCD. As I noted earlier, scrupulosity sufferers often have thoughts that are no different than the thoughts the average person has. The difference is how sufferers think about their disturbing thoughts, the distorted meaning they give them and how that leads the OCD to blackmail them.

Sufferers often believe that "just having a thought means that the thought is important and requires special attention" (Wilhelm et. al, 2006, p. 9). This plays out in a couple of ways. The first is in "moral thought-action fusion." John believed he was as bad for thinking about harming his family as if he actually had done it.

In other words, many sufferers believe that having a bad thought is as sinful as doing something bad. "Individuals with scrupulosity, who by their nature impose strict moral standards upon themselves and are hyper-vigilant of moral/religious sin, might be exquisitely sensitive to intrusive sexual or sacrilegious thoughts that conflict with their belief/value system. For example, a scrupulous individual might find even the passing thought of an extramarital sexual encounter with a stranger more disturbing, and resist it more intensely, than would an individual without scrupulosity, leading to obsessional problems." (Nelson et. al., 2006)

This thinking error is harder to address for sufferers whose religions actually preach this. For instance, in the Sermon on the Mount, Jesus warns, ''You have heard that it was said 'you shall not commit adultery'; but I say to you, that everyone who looks on a woman to lust for her has committed adultery with her already in his heart'' (Matthew 5:27-28; New American Standard Version). Research indicates that many strongly religious Christians, including devout Protestants, incorporate this doctrine into their belief system (Nelson et. al., 2006). But many religious leaders emphasize that they don't expect perfection, and know that OCD forces its sufferers to replay perceived "sinful" thoughts and deeds against their will.

The second way to overestimate the importance of their thoughts is in "likelihood thought-action fusion" (Wilhelm et. al. 2006). Sufferers believe a thought will lead to action, like John worrying that if he thought about harming his family, he would be more likely to do it.

This can also show up in magical thinking: if you think about doing something it will cause it – or something else horrible – to happen. My nine-year-old client wouldn't wear red because it could lead her to the devil, or say "down" because it could send her to hell. Another former client was afraid to wear the earrings she'd had on when her infant had a convulsion for fear that it would cause him to have another one.

Other cognitive errors (Wilhelm et. al.,

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Research Digest

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

This Research Digest presents recent articles on trichotillomania (TTM), compulsive hair pulling. Although classified as an impulse control disorder, TTM has similarities to OCD, is often comorbid with OCD, and many consider it an OC spectrum disorder. The DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) defines trichotillomania as:

A. Recurrent pulling out of one's hair resulting in noticeable hair loss.

B. Increasing sense of tension immediately before pulling out the hair.

C. Pleasure, gratification, or relief when pulling out the hair.

D. Not better accounted for by another mental disorder and not due to a general medical condition (e.g., a dermatologic disorder).

E. Results in substantial distress and/or interferes with functioning.

Currently, behavior therapy is the most effective treatment and medications have only been marginally effective. As you will see below, research is ongoing to improve response to behavior therapy and to find more effective medication treatments. Please remember, promising results of open label trials require confirmation in randomized, placebo-controlled trials. Early promise often melts away under closer scrutiny and patients and doctors must not be mislead about benefit because no treatment is without side effects.

The Trichotillomania Impact Project (TIP): exploring phenomenology, functional impairment, and treatment utilization

Journal of Clinical Psychiatry, 67:1877-1888, 2006, D.W. Woods, C.A. Flessner, M.E. Franklin et al.

Results are presented from an Internet-based survey completed by 1,697 individuals who self-reported symptoms consistent with a diagnosis of trichotillomania (TTM). Survey participants were recruited through a link from the Trichotillomania Learning Center website, www.trich.org. Trichotillomania was found to have a significant impact on social, psychological, academic, and occupational functioning. For instance, 40% of individuals avoided social events because of pulling and 20% of individuals avoided going on vacation because of pulling. The severity of impairment corresponded to the severity of TTM. Individuals did not view their health care providers as very knowledgeable about the disorder. Only 12% felt their provider knew much about TTM and only 3% considered the provider an expert in TTM. Medication treatment with selective serotonin reuptake inhibitors was the most commonly received treatment, followed by behavior therapy. Approximately 60% of those surveyed had received treatment for their TTM symptoms. In general, treatment was perceived as relatively ineffective. Only 5% reported being "very much improved," and only 10% reported being "much improved." The high number of respondents who noted anxiety as both a precipitator and a consequence of pulling is also of interest. Researchers suggest this supports the theory that pulling cycles may be created in which pulling produces the very condition that leads to further pulling.

Behavioral treatment of trichotillomania: two-year follow-up results Behaviour Research and Therapy, 44:359-370, 2006, G.P.J. Keijsers, A. van Minnen, C.A.L Hoogduin et al.

Behavior therapy, using habit reversal strategies, has been shown to be effective in treating trichotillomania (TTM). This study investigated the maintenance of treatment response over time and predictors for continued response. TTM symptoms and other symptom characteristics were evaluated in 28 patients before and after behavior therapy and at 3-month and 2-year follow-up evaluations. Immediately after therapy, TTM symptoms were significantly reduced, but continuation of response was only moderate in the long term. Response had decreased by 49% at 3-month follow-up and 70% at 2-year follow-up. Lower pre-treatment level of depression and complete abstinence from hair pulling immediately after treatment were associated with better 2-year follow-up results. Based on these findings, it is suggested that depressive symptoms should be treated first, prior to treatment of TTM. Additionally as patients in the study who were symptom free after completion of behavior therapy reported fewer TTM symptom 2 years later, TTM treatments should be continued until patients have completely stopped hair pulling.

Escitalopram treatment of trichotillomania International Clinical Psychopharmacology, 22:39-42, 2007, K.M. Gadde, H.R. Wagner II, K.M. Connor et al.

Escitalopram (Lexapro) is a selective serotonin reuptake inhibitor (SSRI). Twenty women with trichotillomania participated in this 12-week open-label trial. Escitalopram was started at 10 mg/day. Based on response and tolerability, dose was increased to 20 mg/day at 4 weeks and to 30 mg/day at 8 weeks. Most patients received doses of 20-30 mg/day. Eight of the 12 women completing the study were responders (67%). Side effects were generally mild and side effects reported by at least two patients included nausea, insomnia, fatigue, lethargy, sweating, dilated pupils, decreased libido and orgasmic dysfunction. In this small study, escitalopram appeared to be an effective treatment for trichotillomania. Further research, using controlled longer studies, is needed to substantiate escitalopram's effectiveness.

Beneficial effects of the antiglutamatergic agent riluzole in a patient diagnosed with trichotillomania Journal of Clinical Psychiatry, 68:170-171, 2007, V. Coric, B. Kelmendi, C. Pittenger et al.

There is evidence that brain glutamate is involved in the pathophysiology of OCD. Riluzole (Rilutek) is a glutamate-modulating medication used in the treatment of amyotrophic lateral sclerosis (Lou Gehrig's disease). It was effective in a small open trial for treatment refractory OCD patients in a study by these same researchers. This is a single case report of a 53-year-old woman with a long history of trichotillomania and depression that had not responded to medication or behavior therapy. Riluzole was started at 50 mg twice a day and over 3 months increased to 100 mg twice a day. At 16 weeks of treatment, her hair pulling disappeared and her depression decreased. At a follow-up visit (72 weeks of riluzole treatment), she reported that urges to pull her hair were minimal and easily ignored and the decrease in depression had persisted. These researchers suggest that riluzole and other glutamate-modulating agents should be studied in controlled trials as treatment of refractory trichotillomania.

Topiramate in the treatment of trichotillomania: an open-label pilot studyInternational Clinical Psychopharmacology, 21:255-259, 2006, C. Lochner, S. Seedat, D.J.H. Niehaus et al.

Trichotillomania (TTM) is classified as an impulse control disorder and topiramate (Topamax) is an anticonvulsant drug that has shown effectiveness in treating several impulse control disorders. This open trial investigated the effectiveness and safety of topiramate in 14

adults with TTM. Patients received 16 weeks of flexible dose treatment (50-250 mg/day). Severity of hair pulling decreased significantly for the 9 patients completing the study. Five patients dropped out because of side effects, the most common being paraesthesia (body sensations), speech/language difficulty (e.g., slowing of speech) and increased anxiety. Researchers suggest that topiramate may be effective in the treatment of TTM and there is a need for controlled trials.

A randomized placebo controlled trial of olanzapine in trichotillomania European Neuropsychopharmacology, 16(Suppl):S452, 2006, M. Van Ameringen, C. Mancini, B. Patterson et al.

Unwanted repetitive behavior is a feature of both trichotillomania (TTM) and tic disorders such as Tourette's syndrome (TS). Antipsychotic drugs are used to control tic disorders and researchers hypothesized that these drugs may work in TTM. Olanzapine (Zyprexa) is an atypical antipsychotic medication. In a 12-week trial, 25 patients with TTM were randomly assigned to treatment with olanzapine (starting at 2.5 mg/day with flexible dosing up to 20 mg/day) or placebo. Eleven (85%) of the 13 patients in the olanzapine group responded compared to 2 of the 12 patients in the placebo group, a highly significant difference ($p<0.001$). Notable adverse effects of olanzapine were dry mouth and increased appetite. Olanzapine may be an effective treatment for TTM.

Attention: OC Foundation Members – Help Us Better Serve You Go to www.nonprofitgroup.net/ocfmember.htm and fill out the Member Survey

Message From the President

(continued from page 1)

While visiting Senator Pete Domenici of New Mexico, a sponsor of the bill, President Bush gave an impassioned speech stating that those individuals with a mental illness deserve our understanding, and a health care system that treats the illness with the same urgency as a physical illness. On April 29, 2002, President Bush asked Congress to pass the Wellstone Bill. The bill has had majority support in several Congresses but has been blocked from consideration by House leadership.

Now this parity legislation is back in play. In February, Senators Kennedy (D- MA), Domenici (R-NM) and Enzi (R - WY) introduced legislation in the U.S. Senate (entitled the "Mental Health Parity Act of 2007") that is intended to require that many aspects of mental health coverage under employee benefit plans be comparable to the coverage provided for medical and surgical benefits. This version of parity legislation does include a number of provisions designed to obtain the political support of employer groups and insurance companies, which some feel is necessary to ensure ultimate passage of a new parity law.

Mental health parity legislation is also back in the U.S. House of Representatives. On March 7, 2007, Congressmen Kennedy (D-RI) and Ramstad (R-MN) introduced the "Paul Wellstone Mental Health and Addiction Equity Act". As with the Senate bill, the House bill provides that mental health parity requirements would apply to group health plans of employers with 50 or more employees. All such benefit plans must provide parity for the first year, and those that can demonstrate that the first year increase in costs is over 2% are allowed to apply for an exemption for year 2. The legislation states that in year three, the employer must again apply the parity rules.

Among the differences between the Senate and House bills is that the House bill would require that health plans offering mental health coverage provide the same mental health and addiction benefits that are provided under the health plans for Members of Congress. The Senate bill has no such provision. In addition, unlike the Senate bill, the House bill would not preempt state laws that provide greater consumer protections, benefits, rights or remedies than provided under the federal parity law.

In an effort to pass parity legislation, Congressman Kennedy and Ramstad have held forums throughout the country. During the national tour entitled, "The Campaign to Insure Mental Health and Addiction Equity", Kennedy and Ramstad have heard testimonies from individuals whose lives have been touched by mental illness and addiction. Employers, mental health professionals and advocates have shared their experiences navigating the health care system. These testimonies will be used to help facilitate upcoming Congressional debates over equal access to health care for mental health and addition treatment.

Affiliates of Mental Health America (formerly National Mental Health Association) and the National Alliance on Mental Illness (NAMI) helped to organize these forums. Peter Newbould, co-Chair of the Mental Health Liaison Group Health Policy Committee (MHLG), contacted the Obsessive Compulsive Foundation and asked for our support. The OCF joined forty-three other organizations working to pass the Mental Health Parity of 2007.

In response to Peter Neubould's request that we ask our membership to attend the hearings, Patricia Perkins, OCF Executive Director, contacted the Affiliates of the OCF and practitioners in the designated regions. She sent emails to the OCF membership and added a section to our website entitled Parity Bill. Jamie Feusner, a doctor from UCLA, attended the forum in Los Angeles and provided written testimony about Obsessive Compulsive Disorder (OCD) and Body Dysmorphic Disorder (BDD). There have been forums in Rhode Island, Minnesota, Maryland, California, Washington, Colorado, New Jersey, Pennsylvania, New York, Oklahoma and Texas. If you would like to attend a forum in your area, check the OCF website (www.ocfoundation.org) for further in formation.

According to Congressman Patrick Kennedy, "if every day we allow insurance discrimination against mental illness is another day eighty-two Americans will die of suicide. It's another day that American business will lose $85 million in lost productivity to depression alone. It's another day that thousands of children will be in state custody instead of home with their parents. It's another night on the streets for 200,00 homeless Americans living with mental illness and addictions. We can not afford the status quo."

Here is your chance to help make a difference. Attend a hearing in your area, if there is one scheduled. If you would like to share your story, contact Patricia Perkins at the OC Foundation and she will lead you through the process.

April 29th is the five-year anniversary of President Bush's call on Congress to pass the Wellstone Bill. Call the White House and remind him of his commitment and that we are still waiting for this legislation to pass. The White House Comment Line is: 202-456-1111.*

To you, the members of the OCF Community thank you for joining the Mental Health Parity Imitative.*

Best Regards,

Joy Kant
President of the Obsessive Compulsive Board of Directors

**If you want to do more, go to page 16 for instructions. Refer to the article entitled "What Can I Do To Get Equal Mental Health Insurance Coverage."*

An Interview with the Treatment Team Running th

In the following interview Dr. Bradley C. Riemann, Ph.D., Peter Lake, M.D., and Karin Beal, M.Ed., talk about a new clinical treatment center for children (ages 8 to 12) with OCD and other anxiety disorders at Rogers Memorial Hospital.

NEWSLETTER: We hear that Rogers Memorial Hospital is opening a treatment center for children with OCD. What's it going to be called and can you describe it for our readers? When will it open?

DR. RIEMANN: We are expanding services at the Child & Adolescent Center (CAC), a residential program that works with all childhood psychiatric disorders. For many years we have been providing treatment for kids ages 12 to 17 who have been suffering from OCD. This expansion will allow us to serve kids ages 8 to 12 in a residential setting. It will provide state of the art treatment for kids with OCD, OC spectrum disorders, other anxiety disorders and co-morbid conditions. This new and separate unit will have highly trained staff with great sensitivity to the needs of children and families. Karin Beal, M.Ed., CYCP, an expert in behavior management of children, will be the manager. Peter Lake, M.D., is the overall medical director of the Child and Adolescent Center; Lauri Green, M.D., a board certified child and adolescent psychiatrist, will be the attending physician and I will give clinical supervision to the CBT services. We have been thinking about providing this program for quite some time, thoroughly investigating whether it was needed; and if so, how we could make it the best program possible. Positive treatment outcomes for the teens encouraged us to go forward. We are looking at an opening in middle to late April 2007.

Dr. Bradley Riemann

NEWSLETTER: The children that would be in this program are quite young. How is the Center going to be staffed to handle the unique problems of young children away from their homes, families and friends?

DR. LAKE: We're fully aware of the issues that providing care to this age group bring. The program will have a high staff to patient ratio with a team that includes board certified child and adolescent psychiatrists, behavioral therapists, experiential therapists, nurses, social workers, and certified teachers. The approach will be multimodal (individual, group, family therapy, psycho-education, medication management). The children will have individualized treatment plans to address their specific issues. Family sessions and parent education will be an integral part of the program. We want strong communication with the family and will provide weekly family sessions and family programming twice a month. We encourage visitation. These children will be safe within our care, with the goal of returning them back home with a reduction in their anxiety symptoms and improved daily functioning.

Dr. Peter Lake

NEWSLETTER: Who would you consider to be the typical patient for this Center? Would it be children with severe OCD? What would you describe as severe OCD?

DR. RIEMANN: We anticipate getting kids with severe OCD or other anxiety disorders with significant co-morbidity and complex presentations. Severity is determined by how much the OCD impairs a child's functioning. If the OCD is keeping the child from going to school, being social with friends and creating behavioral challenges within the home, this program may be what they need. We will be utilizing the CY-BOC (The Yale Brown Obsessive Compulsive screening modified for kids) as part of our screening process.

NEWSLETTER: How is the Center going to be staffed? Will there be nurses and mental health workers there 24 hours a day?

KARIN BEAL: Absolutely! The program will be highly staffed 24 hours every day. We are looking at a 4 to 1 patient to staff ratio, with nursing available, if needed, at any time of the day.

NEWSLETTER: How many patients will you be able to treat at the Center at one time?

DR. RIEMANN: At present time this will be a ten bed program.

NEWSLETTER: What treatments for OCD are you going to offer at the Center? CBT? Medication?

DR. RIEMANN: We will be emphasizing exposure and ritual prevention with some cognitive therapy being implemented on an individual basis. Some children may not have the capability to do full blown cognitive therapy. We will use a more child friendly approach we call "Safety thinking" for kids who are not able to participate fully in the cognitive therapy process. This approach is a less formal, typically verbal versus written thought challenge, which is often helpful in working with kids. Because we know some individuals with OCD benefit most from a combination of CBT/ERP and medications, each child will meet regularly with a board certified child and adolescent psychiatrist to assess and review the use of medications. Administration of medicine will be tightly overseen by the physicians and nursing staff.

Karin Beal, M.Ed.

NEWSLETTER: Will the children you are treating at the Center be old enough or developed enough to take typical SSRI medications?

DR. LAKE: Yes, but let's qualify. Medication management is a highly individualized treatment decision made between the physician and the family. The benefits and side effects of any medication will be fully explained so an informed choice can be made. If medications are used it will be under intensive case management by the physician and the nursing staff. But let's expand on our involvement. Dr. Green and I meet with kids for more than just medication checks. As physicians we dedicate time daily to sit down with children one on one to provide therapy, evaluate how their doing and review their progress.

he New Child Center at Rogers Memorial Hospital

NEWSLETTER: How many hours a day will the children do CBT, specifically exposure and response prevention exercises? Will they do them with a therapist or alone?

DR. RIEMANN: Four to five hours of each day will be dedicated to the treatment of OCD and other anxiety disorders. The vast majority of those hours will be one on one therapist-aided ERP with some supervised homework.

NEWSLETTER: What would a typical day be for a child at your Center?

KARIN BEAL: Here is a sample schedule.

Monday – Friday

CBT/ERP Homework Review

CBT Challenge Programming and Experiential Therapies – art, leisure, recreation, adventure

Lunch/Recess/Free time

School and Nutrition Education

CBT with Social Services and Behavior Therapists

Snacks

CBT Homework

Dinner / Recess / Free time

Challenge Programming, Skill Development, and Experiential Therapies

"Family Time" – Showers, Snacks, Games, Phone Calls

Saturday and Sunday

CBT and Exposure Homework

Academic Homework

Challenge Programming, Experiential Therapies, Skill Development

Family Programming x2/month

NEWSLETTER: How long is the typical program supposed to last?

DR. RIEMANN: We anticipate an average length of stay of 6 to 8 weeks.

NEWSLETTER: What if a child does not have her OCD sufficiently under control at the end of the typical program? Will he or she be able to stay at the Center until s/he has his/her OCD under control?

DR. RIEMANN: A child who is actively participating and continuing to benefit from the program will be encouraged to continue. The treatment team will involve each family in the decision to keep a child in the program.

NEWSLETTER: Is there a school at the Center? If not, is there any way a child will be able to stay current with his/her school work?

KARIN BEAL: Children should come to the program prepared to participate academically. We will encourage families to bring a week's worth of homework, as well as an IEP, FBA, or BIP if one has been established for the child. Our teachers will coordinate academic work with each child's school or special education placement. We will provide about one hour each day to attend school with additional time scheduled to complete "homework."

NEWSLETTER: The children who are going to be patients at your Center will be pretty young. Are their parents and families going to be integrated into their treatment? Will parents be taught how to work with their child and not become enablers?

DR. RIEMANN: Parent education will be a major component of the program. We want parents to feel confident enough to take on the role of "coach" when a child returns home. Initially, parents will need to be heavily involved in the hierarchy development. Parents will get weekly updates on their child's progress and will be invited to attend family programming. In addition, parents are encouraged to maintain contact through phones calls and visitation.

NEWSLETTER: What do your treatment providers do to equip the child for the possibility of relapse?

DR. RIEMANN: All individuals will be encouraged to complete 70% of their hierarchy. Our research has shown that those who complete through this level have an 83% chance of maintaining their gains. When this is achieved the odds of relapse decrease significantly. Children and parents will receive information about the warning signs of relapse and what to do if these signs present. Rogers Memorial Hospital maintains a large network of outpatient providers who are highly skilled and trained in treating OCD. Each child will be set up with an outpatient treatment team if he or she does not already have one. We are aware though that expertise with this disorder does not exist in all places nationwide. I'm sure many of the families who receive this newsletter can attest to that.

NEWSLETTER: What kind of activities do you have for the children when they are not working on their OCD?

KARIN BEAL: The program will include age specific recreational therapy (ropes and challenge course, hiking, biking, camping, art, etc.), leisure education, and fitness opportunities. Our experience with children and teens has been that kids not only need outlets for their energy but learn and progress therapeutically with experiential activities. We will provide a variety of safe and healthy ways for kids to express themselves.

NEWSLETTER: Is there evidence supporting this type of intensive treatment for children of this age?

DR. RIEMANN: Our experience with the teen program (ages 12 to 17) has been very encouraging. We have confidence that the team we have assembled and the program we have created specific to kids will be successful.

NEWSLETTER: Will private insurance cover your program? State health insurance plans? Medicare? Is there anywhere parents can get help to pay for this program?

DR. RIEMANN: We are contracted with many of the major networks. The admissions department will help to determine if we are in plan; and if so, if there is a benefit for this level of care. A number of states have contracted with us on a per case basis due to the lack of appropriate intervention in the home state. Unfortunately, many families cannot secure funding through their state and there is no easy answer to this question. Medicare does not have a residential benefit. Self-pay is an option for some families, prohibitive for others. We just encourage families to call to see if we can be a viable treatment option.

NEWSLETTER: If a parent is interested in your program, how can he or she get in touch with you?

DR. RIEMANN: Parents can call our toll free number, 800-767-4411, and ask to speak with an admissions' representative for The Child Center. Parents may also visit our website www.rogershospital.org for more information.

OCD – A Mother's Story

By Lisa Buchanan
Support Group Leader
Plano, TX

In October of 2004 my son's life, my life, and my family's life changed forever. My 8-year-old son, Conner, developed Obsessive Compulsive Disorder. Fortunately I had an awareness that excessive hand washing was something called OCD, but I had no idea what OCD really looked like and definitely had no idea how to "fix" it for my son. It is truly torture, but there is hope. This is our story.

A few days before Halloween when my son was in third grade, he became very nervous about some pellets that had been sprinkled on the lawn by our lawn service. I could tell he was having great anxiety about it and was asking a lot of questions. He had decided that since his shoes touched the grass, the shoes would now have to go and could no longer be worn. I thought this was peculiar but still didn't think too much about it. He also didn't want to play outside any longer. He'd really put up a fuss about going outside, and he'd cry and I'd give in. The poor kid just wasn't an "outside" kinda kid, so I thought. There were other little odd things that had been happening for a little while such as Conner not being able to watch a certain preview for a movie. It made him very anxious, then he eventually didn't ever want to go to the movie theatre for fear of seeing this preview. He could play video games for hours if I let him and would get very upset and cry when it was time to get off the games. He occasionally paced back and forth, but we couldn't figure out why. When we asked him why he was pacing, he'd say, "I don't know." I just chalked it up to his way to relieve stress.

October 30th, 2004: My husband was going to take the kids fishing. Conner has an older sister and younger brother, and they love to go fishing with Dad. We go to a local pond where we spend an hour or so just having fun. Conner usually loves going but not today. We had decided instead of fishing, he now needed new shoes and that he and I would do that instead. Dad and the other kids left, and Conner and I started to pull out of the driveway to head to the shoe store. All of a sudden I heard sobbing from the backseat and realized Conner was crying very hard. I asked, "What's the matter, buddy." And his reply was, "I'm afraid of my life." I asked, "What are you afraid of?" and he replied, "Everything."

I was confused and could not understand what was happening to my child. I started to go down the list. " Are you afraid of dying?" "Sometimes." "Are you afraid of Mommy and Daddy dying?" "Sometimes." He was still crying and the tears were not letting up.

"Sweetie, can you tell me what you're afraid of?" Finally he said it. The classic OCD phrase. "I'm afraid something bad might happen." Of course, I had no idea what that meant. What did he mean – something bad – that could be anything. It seemed so bizarre. I stopped the car and looked back at him to ask what he meant by "something bad" and noticed he was sitting with his hands on his knees with his palms facing up. I asked, "Conner, why are you holding your hands like that?" He is sobbing, "I don't know. I'm afraid to touch things." This, for some reason, because of some PBS show or something on "20/20," made me think about OCD.

I decided to go to a park because I felt we both needed some fresh air and to walk. We drove to a park close by, and we both started to get out. That is when what I call the "breakdown" happened. Conner now calls it #20 on his Feelings Thermometer, which actually only goes to 10. It was a very bad day. In fact, it was one of the worst - right up there with the death of my Dad when I was 19 years old. Conner began to cry uncontrollably and pleaded with me not to make him walk on the park path. I said in a panic, "Conner! What is wrong!" "I'M AFRAID OF THE TREES AND THE PLANTS AND EVERYTHING OUTSIDE!"

I truly thought my sweet 8-year-old little boy was having a nervous breakdown. I encouraged him to sit on a bench by me, and when I reached over to comfort him, he pulled away quickly. I asked again – but this time much more quietly. The truth is, I was terrified. "Conner. Sweetie. What is the matter?" He replied, "I'm afraid if you touch me something bad might happen to you." I asked him if he would feel better if we went to the emergency room. He said, "I don't know."

I made the decision to go home. The minute we walked into the house, Conner headed straight for the bathroom and washed his hands multiple times. That is when I knew in my heart that it was OCD. I immediately called a therapist and set up an appointment for Conner. We had a few more days before we'd see the therapist, so I decided to get on the internet. All I could find were stories of tortured lives, sadness, depression, and no hope for my child. I thought he may someday have to be institutionalized.

At that point, if he had a bad day, I had a bad day. If he had a good day, I did also. I started reading everything I could get my hands on dealing with OCD. Luckily, I did find a book that helped me tremendously and gave me hope. It was *What to Do When Your Child Has OCD* by Dr. Aureen Wagner. I cried every night and felt like I had lost the little boy I had a week ago. I was grieving a loss. This child couldn't play outside anymore; he couldn't even play with his brother. He was extremely depressed and terrified of things that didn't make sense. We went to the movies, and he was afraid the soda had poison in it.

After reading all of Dr. Wagner's book and then also meeting with the therapist, we started exposure and ritual prevention (ERP). In addition, Conner read *Riding the Worry Hill* (a child's book by Dr. Wagner), and we began to ride. Here's a literal example of what we did to "ride the hill:"

Conner was scared of poison (contamination) and was very afraid of leaves, grass, etc. A leaf had blown in and was on our living room carpet. Well, the anxiety started, and Conner was paralyzed in the hall, which happens to have a hardwood floor instead of carpeting like the living room. He now could not come into the living room because of the leaf on the carpet. He could not touch the carpet. He was trapped. Literally. I picked up the leaf and threw it out the door. Bad move. Now I was contaminated. I had to wash my hands. (I didn't know at this time that I was accommodating the OCD.) So I washed my hands, but Conner was having a full blown panic attack in the hall and couldn't touch the living room carpet. I had a flash of a child that would have to eventually live in his closet and could never come out. I finally decided we needed to ride this damn worry hill together!

I said in a forceful voice, "Conner, come over here to me." He was crying at this point and shook his head "no." "Conner, we're going to ride the worry hill together, and you will see that nothing bad will happen to either one of us. Now come here and I'll ride with you." I stood in the exact spot where the leaf had been. He didn't want to, but he came to me sobbing and we held each other tight. Now I started the coaching. "OK . We're going up the hill. Are we at the top yet?" By this time he was crying so hard and breathing very fast. "No!"

"Are we half way up the worry hill?" "Almost, Mom!" He was breathing so fast and so hard and I could feel his little heart beating out of his chest. I held him tighter. "We're almost there aren't we?!" I said. "Yes! Almost!!" he cried. I started to cheer him on. "You can do it, Conner! You're almost to the top. Hold on. Hold on!" He finally said, "Mom, we're at the top!" I said, "I knew you could do it, Conner! Now we just coast to the bottom and look, nothing bad has happened to us. We're still here. We're OK." He just sighed and was exhausted but there was a tiny smile on his face. He had won and the next hill would not be as big.

Informal Mindfulness Training Improves Treatment Response for People with OCD Co-morbid with PTSD

Eda Gorbis, Ph.D.[1], Chris Molnar, Ph.D.[2], and James Sterner, M.A., M.F.T.[1]

Until recently cognitive-behavioral clinicians have had only minimal success in treating people whose obsessive compulsive disorder (OCD) is comorbid with post-traumatic stress disorder (PTSD) symptoms. In our practice, we have discovered that a comprehensive treatment strategy that we refer to as Mindfulness Based Behavioral Therapy (MBBT) improves treatment response in those who have been dubbed "treatment resistant" by many previous cognitive-behavioral practitioners and psychiatrists.

In MBBT we incorporate informal mindfulness training as described in Jeffrey Schwartz', "Brain Lock" along with exposure and response/ritual prevention (ERP) as described in Drs. Michael Kozak and Edna Foa's treatment manual, "Mastery of obsessive-compulsive disorder: A cognitive-behavioral approach — therapist guide." As well, when warranted we integrate behavioral interventions not often used in clinical research trials along with ERP such as behavioral activation, time management, and priority management. We also collaborate with psychiatrists for medication intervention when warranted. Finally, Dr. Gorbis has developed a writing intervention with both behavioral and mindfulness components that contributes to treatment response.

Intervention using MBBT reduced OCD symptoms by 59% in a group of 139 adults who had multiple co-morbid conditions and consented to participate in an uncontrolled treatment trial at the Westwood Institute for Anxiety Disorders. Participants were previously unresponsive to many medication and psychotherapy interventions received elsewhere. Next, we elaborate on our treatment approach for OCD when it is co-morbid with severe trauma-related co-morbidity including post-traumatic stress disorder (PTSD), dissociation, somatoform, and mood symptoms.

When trauma-related symptoms are present in a person with what appears to be primary OCD, the failure to target the PTSD symptoms in treatment planning can diminish the outcome of ERP treatment. To date no randomized controlled treatment outcome trials have been conducted on treatment for people with primary OCD that is co-morbid with PTSD symptoms; however, one group did report on the failure of behavioral treatment for such a group compared to those without co-morbid PTSD (Gershuny, et al., 1992).

At the conclusion of this article, we present outcome data from two people, with especially severe symptoms, who sought treatment for primary OCD and had co-morbid PTSD symptoms. We actually found improvement in all 10 of our cases with co-morbid OCD and PTSD symptoms. Here, however, we report only on the two most severe cases to offer hope to those with even severe symptoms. The results of the larger sample have been submitted for publication elsewhere. We think that part of our success is that we always ground our interventions in the research-based theory of exposure treatment referred to as "emotional processing theory" (Foa & Kozak, 1986).

Specifically, emotional processing theory indicates that each individual has a "fear structure" that explains the occurrence of anxiety disorder symptoms and holds within it a guide to the new learning that must occur if symptoms are to decrease. The fear structure contains maladaptive stimulus, response, and meaning elements that must be modified through treatment. For example, a person with both OCD and PTSD may have the following fear structure:

The OCD symptoms that occur upon exposure to the stimulus of a dirty toilet evoke a response of washing because the stimulus of a dirty toilet is associated with meaning elements such as "toilet seats are where people sit with naked genitals" and "genitals are dirty." In a person who also has PTSD due to a history of sexual assault, the fear structure may also be associated with the stimulus of a toilet seat because of a unique learning history that resulted in the meaning element, "Naked genitals cause emotional and physical pain, are bad and should be avoided." Such a meaning element may result in a response such as excessive cleaning of the genitals and avoidance of toilet seats in an effort to keep the genital area clean. This helps him or her to avoid the memory of emotional and physical pain that has become linked to "dirty" genitals. In a client with the above fear structure, and associated co-morbid OCD and PTSD symptoms, it is crucial to expose the person to learning that will not just modify the OCD fear structure elements, but also the PTSD elements. Otherwise relapse is inevitable and maladaptive symptoms will continue to exist. Thus, treatment must teach this person that genitals are not always associated with the outcome of emotional and physical pain.

The complexities of co-morbid disorders, as illustrated, indicate why, prior to the onset of treatment, we conduct an extensive assessment. This must be done so that we can ground our MBBT program in sound emotional processing theory and proceed with our integrated approach.

The addition of informal mindfulness training to ERP is crucial to our success with ERP for several reasons: Mindfulness is associated with a decrease in the automatic reactivity so typical of people with anxiety disorders. Such reactivity results in compulsions and other behaviors aimed at the immediate decrease of emotional pain. These behaviors only reduce pain in the short term and actually maintain anxiety over the long term.

Mindfulness ensures that a person directs attention to the actual outcomes of treatment. Such outcomes include: (1) feared outcomes do not occur and/or can be coped with, and (2) the important learning that the fear, sadness, anger, and disgust that seem so unbearable and are associated with the fear structure will peak and pass even without maladaptive compulsions and other behaviors. Mindfulness teaches an important lesson to be learned about the impermanence of everything and everyone. This learning is crucial for sufferers who seek control over what is not controllable. It is important to note that we do not teach formal mindfulness training referred to as mindfulness based stress reduction (MBSR) at the Center because formal mindfulness training differs from informal mindfulness training in that the former requires a minimum of 45 minutes of daily meditation practice (Kabat-Zinn, 1990; www.umassmed.edu/cfm). We hypothesize that this more rigorous training would further improve outcome and have applied for funding to evaluate this possibility. Indeed, much evidence supports the hypothesis that formal mindfulness training reduces the unnecessary distress so typical of other anxiety and mood disorders (Baer, 2003; Bishop, 2002).

(continued on page 17)

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Book Review

Compulsive Hoarding and Acquiring

By Gail Steketee, Ph.D., Boston University School of Social Work, and Randy Frost, Ph.D., Smith College

Review by Jerome Bubrick, Ph.D., Private Practice Montclair, NJ

I am honored to review *Compulsive Hoarding and Acquiring* in the "Treatments That Work" series by Gail Steketee, Ph.D., and Randy O. Frost, Ph.D. The truth is when two prominent researchers and clinicians get together and write a book, the review process is quite easy. *Compulsive Hoarding and Acquiring* is a welcomed empirically-based treatment manual for compulsive hoarding and should help many people with the often debilitating condition. *Compulsive Hoarding and Acquiring* comes in the form of a therapist guide and a client workbook. They work hand-in-hand and direct the clinician-client team through the different stages of psycho-education, treatment and relapse prevention. Both are written with a very friendly, but directive tone; and the reader instantly recognizes the authors' knowledge of compulsive hoarding.

The Client Workbook is clear in making the point that it is to supplement the treatment by a clinician. It contains interactive worksheets that allow the client to record thoughts and beliefs as they occur naturally, complete rating assessments, formulate treatment goals and do cognitive and behavioral experiments. Additionally, there are "personal session forms" that allow the client to take meaningful notes during sessions under clear subheadings including: agenda, main points, homework to discuss next time and intervention strategies used. If needed, the client can download more worksheets from the "Treatments That Work" website.

From the first pages of the book, the Therapist Guide educates its readers about compulsive hoarding, including prevalence, insight, co-morbidity, and the scientific evidence that supports their approach. They emphasize the need for a therapist-client collaboration and give the clinician methods to incorporate the Client Workbook into the treatment. The authors recommend that clinicians read through the entire book first to become familiar with the model and treatment approach prior to working with clients. This I find an especially good point, because there is often a great deal of variability between clients, so having a thorough understanding of the treatment and its components is essential to providing effective treatment. Furthermore, they structure and explain the cognitive and behavioral model of compulsive hoarding so soundly that both the seasoned CBT therapist and newcomers alike can understand the condition well.

The intervention program is divided into several distinct phases including: Assessment, Case formulation, Skills training, Exposure and Cognitive therapy, Motivational interviewing, and Relapse prevention. The treatment is designed to occur over a six month period, but it can be longer or shorter depending on the severity of the hoarding.

What I really like about the book is the development and use of new and creative exercises. For example, within the Assessment phase, the authors provide several assessment measures including rating scales on saving and discarding, activities of daily living, and beliefs about saving. They have included a great new scale called the "Clutter Image Rating Scale" that gives the client pictures of varying degrees of clutter in sample rooms, including a bedroom, kitchen and living room. The client is then asked to match his/her level of clutter in his/her own corresponding rooms. I think this is a wonderful addition to the existing resources, as it is likely to prompt the clients to provide more accurate and valid ratings of their clutter.

The clutter and unclutter visualization is another innovative exercise to help assess a client's motivational status. Essentially, clients are asked to visualize cluttered spaces and then visualize those same spaces without clutter and give feedback on their thoughts and emotions. If it appears to the clinician that motivational or insight issues may impede the treatment process, wonderful suggestions and techniques are offered in the motivational interviewing chapter.

When reading the chapters on problem-solving and learning a personalized organizational system, the reader truly sees how much experience the authors have in clearing clutter and maintaining a clutter-free situation. They give a wide variety of organizational skills and suggestions, such as how to categorize and organize papers, how to set up a filing system with commonly used filing categories, and guidelines are given on how long to keep certain items, like tax returns and credit card receipts. Again, the use of the Client Workbook reinforces what is learned in sessions, and the clients are able to use their own worksheets to develop their own system.

The chapters that address exposure with response prevention and cognitive therapy truly reflect the authors' knowledge of and experience with treating hoarding. The case vignettes provide superb direction in how to facilitate change without being forceful or antagonistic. I really liked the section that challenges the clients' wants versus needs with respect to acquiring. This is a huge distinction to be made in order to reduce the acquisition of new items.

Gail Steketee and Randy Frost have created a grounded, well-organized and soundly written treatment manual for an extraordinarily difficult condition. I highly recommend this book for everyone who suffers from compulsive hoarding and for those who want to successfully treat it. The only problem I have with this book is that one copy won't be enough, you'll probably need to purchase three!!!

OCF Genetics Collaborative Meeting

The fifth annual meeting of the Obsessive Compulsive Foundation Genetics Collaborative (OCFGC) was held on February 24 & 25 on Amelia Island, Florida. Forty-eight individuals representing 29 different institutions and the Obsessive Compulsive Foundation attended the meeting. Dr. Steve Faraone, Professor of Genetics at the State University of New York Medical Center, was the keynote speaker. Dr. Faraone is the chair of a similar group focused on the genetics of attention deficit hyperactivity disorder (ADHD) and spoke to the group about the activities of the ADHD Consortium in order to provide some guidelines as to how the OCFGC could continue to work together productively and develop more groups for collaborative research.

The main focus of the meeting was to discuss whether the group would undertake a Whole Genome Association study for OCD and, if so, to begin to develop a plan to complete such a project. Due to the generosity of a private donor, it has become possible for all members of the group to combine the DNA samples collected at each site for a study designed to identify susceptibility genes for OCD. Whole Genome Association studies have recently become feasible because of significant advances in both molecular genetic technology and statistical methodological advances. These studies provide much more power in the search for genes important for complex disorders and have proved successful in the identification of genes for other conditions, such as age related macular degeneration and diabetes.

A number of sites that are part of the Obsessive Compulsive Foundation Genetics Collaborative have already collected data and DNA samples from a large number of individuals with OCD and the group decided that it would proceed with a plan to combine all of these samples to create one large sample for this work. The group identified several criteria that needed to be met in order for a specific individual to be included in the study and selected a Steering Committee to develop a research plan and to oversee the project. This committee consists of individuals from ten different sites in five different countries representing clinicians, molecular geneticists and statistical geneticists. The members of this group are: Dr. Paul Arnold from the University of Toronto, Dr. Damiaan Denys from the University of Amsterdam, Dr. Gregory Hanna from the University of Michigan, Dr. Peter Heutink from the Free University of Amsterdam, Dr. Ana Hounie from the University of São Paulo, Dr. James Knowles from the University of Southern California, Dr. Carol Mathews from the University of California, San Francisco, Drs. Gerald Nestadt and Yin Yao from the Johns Hopkins University, Dr. Humberto Nicolini from the University of Mexico, Drs. David Pauls, Shaun Purcell and Evelyn Stewart from the Harvard Medical School and Dr. Michael Wagner from the University of Bonn.

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Scrupulosity: Blackmailed by OCD in the Name of God

(continued from page 5)

2006) include Control of Thoughts: When people try to control their thoughts, they usually find the thoughts become harder to prevent. (Try that old experiment: first attempt to think about a brown bear for five minutes, noticing how often your mind drifts. Then try not to think of it for five minutes. You discover that a thought becomes more tenacious when you try to stifle it.) Scrupulosity sufferers are distraught that inappropriate thoughts enter their mind. Instead of dismissing them with a shrug as people without OCD do, they become horrified that they had the thoughts at all and try to stifle them, which has the opposite effect.

Intolerance of Uncertainty: Sufferers need to know absolutely that they are morally or religiously in the right because they believe that the consequences, such as eternal damnation, will be severe if they are wrong. For example, when John tried to reassure himself that he was good, it led to overanalysis of his past thoughts and deeds, paralysis, and senseless rituals and avoidance.

Emotional Reasoning: People with OCD think that if they feel something, it must be true, regardless of the evidence. So even though John knew he was committed to keeping his children safe, if his senseless harm obsessions worried him, he took that worry as evidence that they truly were in danger from him.

All-or-Nothing Thinking: Scrupulosity sufferers believe that if they don't practice their faith perfectly, they have failed. When John had a bad thought in church, it virtually wiped out the good in his otherwise constant devotion.

It has been observed that "the clinical manifestation of scrupulosity may arise from the fear of negative religious consequences (e.g., punishment from God, eternal damnation) resulting from inability to control intrusive thoughts (e.g., sexual, sacrilegious) that are perceived as sinful and morally unacceptable (i.e., equivalent to sinful behavior). In an effort to reduce obsessional distress, individuals engage in compulsive (neutralizing) behaviors such as excessive prayer, confession, and checking for reassurance from religious authorities, among other strategies." (Nelson et. al., 2006, p. 1083).

John learned to correct his thinking errors by challenging them with me. He also used behavior therapy as a way to challenge those thoughts in a different way: to take their power to control him away by reducing their sting.

Behavioral Therapy: Exposure and Response Prevention

With exposure and response prevention (ERP), John learned how to tolerate his obsessions instead of running from them, which takes away the power of those thoughts. His mind and body habituated to the anxiety triggered by the distressing thoughts. He learned how to label those obsessions as OCD, not truth, and let them go. The thoughts eventually became less disturbing and then less frequent. In conjunction with cognitive therapy, it was a powerful weapon against his OCD.

Habituation

ERP is the OCD sufferer's equivalent of jumping in a cold pool. In ERP, sufferers choose to accept and tolerate the initial discomfort of their bad thoughts, despite their desire to chase those thoughts away with compulsions.

Likewise, swimmers often need to accept and tolerate the cold water when they enter a pool. If they immediately jump out, they will feel relieved to be out of the cold. This quick reaction reinforces their belief that cold water is unbearable and avoiding it is the only smart move. If they jump back in periodically but always flee before they get used to it, they continue to reward the getting-out (avoidance) behavior. They've reinforced that the cold is obviously too awful to tolerate, which just increases their distress when they imagine trying again.

However, if they stay in the pool until they get used to the chill, they adjust and become more comfortable. If they repeat that exercise a dozen times a day, they reinforce the message that tolerating the cold leads to getting more comfortable. With time they get less scared of the initial disturbing chill and the irrational belief that it will last forever, and they find waiting it out pays off with reduced (or even no) discomfort.

It's the same with scary thoughts. When John was afraid of thoughts of harming his children and going to hell, he neutralized them by keeping away from the kids, and by repeating phrases about God that reassured him that he was a good Christian man. But the thoughts just kept returning and he'd have to continually avoid his kids and repeat useless phrases for minutes and later for hours. I clearly determined that he was not a danger to others, or to himself. So I didn't worry about having him in situations that his OCD made him feel might be dangerous for others.

Thought Exposure (the E in ERP)

We made a hierarchy of his obsessive thoughts, from the least to most disturbing. We created a thought exposure exercise for him. He listened repeatedly to a tape he recorded with a script about Satan making him harm his children. He listened to the tape, read the script he'd written for it, and re-wrote the script for a total of 60 minutes each day.

Then we added frequent quick thought exposure exercises that would trigger the anxiety. He typed "sold to D" for devil on his Blackberry, which beeped hourly and put post-it notes with "sold to D" where he'd see them. He took his laptop to his car during work breaks and watched "The Exorcist," which triggered his anxiety.

Behavioral Exposure

Later we added physical assignments, as he could handle them, of rough-housing in a pool with his children, bathing them, and using knives around them in the kitchen.

Response Prevention (the RP in ERP)

John did not allow himself to do any compulsions or safety behaviors to quell the anxiety, such as avoiding his children or repeating his reassuring phrases. He taunted his OCD with the behavioral and thought exposure exercises. As a result, he habituated to those anguishing thoughts - they stopped disturbing him as much and soon he stopped having them as much. The OCD thoughts lost their power.

After several months, he had significantly reduced his anxiety and was exhilarated at being able to regain his affectionate way with his children. However, while he'd accepted that his harm obsessions were irrational and he had dismissed most of them, some remaining scrupulosity fears about his likelihood of going to hell still had a toehold.

For his last thought exposure exercise, he wrote a final fictional script for himself:

> *It's Wednesday afternoon and my weekly appointment with Laurie. Only this week is a little different. [Pastor] Jane is joining us from a nearby church. She sits down and asks, "So what is the issue?" Laurie goes through the medical explanation of OCD. Jane looks at me and asks, "What does this have to do with you?"*

I respond, "I am afraid I may have sold my soul to the devil." Jane responds, "It is the church's belief that if you're afraid you did then you must have done it. There is no such thing as a chemical imbalance in the brain. You are doomed to hell. You have done the unthinkable. There is no hope for you to find salvation once you have done the unthinkable." Hearing Jane say it out loud makes me realize it must be true. I must have done it. Laurie was lying to me to make me feel better. I truly am an evil person. In my weakened state, I turn to my wife for help and explain the scenario. She backs away in total fear, yelling, "HOW COULD YOU DO SUCH A THING! YOU DISGUST ME!" She takes the kids and files for divorce. I go on to live my life in solitude, sorrow and regret, never to see my wife or the kids again."

This was his last step in overcoming his OCD; and it worked. The more he listened to the tape, the more he was able to see how irrational his fears were, and to let them go. He was freed from his scrupulosity.

The bottom line is that people with scrupulosity can maintain their faith and stop being blackmailed by their OCD. A man with scrupulosity wrote to a fellow sufferer on a scrupulosity listserv:

...It doesn't matter what you "feel" right now. Your salvation doesn't depend on your feelings. Human feelings are temporary and transient. Instead of trusting in your feelings or in your own goodness, trust his promise...whoever believes in him shall not perish but have eternal life. It doesn't say whoever has perfect belief has eternal life, and it doesn't say whoever is perfect has eternal life, or whoever is without bad thoughts has eternal life. You've already accepted Christ, your salvation is secure, no matter what your OCD tells you. And I believe your bad thoughts (and mine) don't matter to Christ... he sees them for what they are...a brain glitch, a chemical imbalance, etc. I've noticed that a lot of people in the group are worried that they've committed the "unpardonable" sin...But, anyone who worries about committing the unpardonable sin hasn't committed it...You've not been "cut off" ...that's just an OCD lie... (The Scrupe Group, 2006).

Laurie Krauth is an Ann Arbor, Michigan, psychotherapist specializing in the treatment of anxiety disorders, including OCD, as well as the treatment of depression, relationship and LGBT concerns. She is a scientific advisory board member of the Obsessive-Compulsive Disorder Foundation of Michigan. Links to OCD resources and contact information is available at www.LaurieKrauth.com.

On Attending a Mental Health Parity Forum

By David L. Kupfer, Ph.D.
Falls Church, VA

On January 29, 2007, Representative Chris Van Hollen (D-MD) hosted a public hearing in Rockville, Maryland to put a human face on the need to legislate parity for mental health and addiction treatment in the health care system. Those who attended heard statements from six members of congress, patients and family members who felt mistreated by the current health care system, and from professionals with knowledge of the effectiveness of mental health treatment and the great cost of denying care. This hearing was one of several being held around the country to generate support for the "Paul Wellstone Mental Health and Addiction Equity Act."

It is worth noting that several of the congressmen at the hearing have personal experiences that have led them to be interested in this issue. Patrick Kennedy (D-RI) and Jim Ramstad (R-MN) are recovering from problems with addiction. Tim Murphy (R-PA) and Brian Baird (D-WA) are psychologists. They are not alone in being sensitive to the parity issue. Every year since 2002, this bill is actually co-sponsored by a bi-partisan majority in the House. But the House leadership in the past has not brought it up for a vote. President Bush has pledged his support of his bill. The congressmen at the hearing believe that this year a Democratic Congress may be able to hold the President to make good on his pledge.

Several speakers spoke of frustrating personal experiences in dealing with the current health insurance system that seems to discriminate against those with mental health needs. A father described years of efforts to get good care for a daughter with bulimia. He found no true eating disorder specialists on the insurer's panel, and had to pay more to go out of network to find competent providers. He found that inpatient centers had trouble treating his daughter when the insurer would dole out authorizations only two or three days at a time. Because of the lack of equity and insurance denials, his daughter received care that ended up being more expensive, since she had to to to emergency rooms and get treatment for the medical problems that resulted from the untreated psychological syndrome. His testimony led Representative Kennedy to mention the need for "pay equity" to make sure that insurance panels include providers who are competent in a wide range of mental health specialties. The representatives seemed well aware of the "phantom panels" that make certain health care plans look more helpful than they actually turn out to be.

A recovering alcoholic recalled his insurance company first authorizing his inpatient chemical dependency treatment. Later, he was denied payment for this care, claiming that he did not meet their medical necessity criteria. Kennedy responded to this story by noting the importance of "transparency" in written descriptions of insurance coverage, enabling consumers to know in advance what benefits (and limited access to these benefits) they are buying.

One witness, Dr. Steven Sharfstein of Sheppard Pratt, presented his desire for managed care companies to be held legally accountable for the consequences of their decisions, just as providers are held accountable. He also helped the legislators understand that unqualified managed care personnel, either clerical staff or mental health professionals knowing very little about relevant specialty areas, are often making important decisions that affect treatment. Another speaker, Dr. Harold Eist, past-president of the American Psychiatric Association, referred to managed care as "managed denial; there is no care in it."

Other expert witnesses described the cost of untreated mental illness. Crime, absenteeism, lack of worker productivity, and medical problems often result from mental health benefits being inadequate or difficult to access. Perhaps 80% of juveniles and adults in jail have untreated psychological or substance abuse problems. Immigrants often have to choose between paying the rent or the deductible, and military officers returning from Iraq are underserved as well. Witnesses expressed frustration with those who see brain disorders as less worthy of treatment or insurance coverage, compared to disorders involving other organs. The House members present spoke of their awareness that the stigma of mental health problems has led to a reluctance for patients to come to Congress to be their own advocates. Representative Kennedy referred to this stigma as "the last discrimination allowed in our society."

Representative Baird spoke clearly about the powerful opposition to parity bills. Small businesses, represented by the National Federation of Independent Businesses (NFIB), oppose this bill. This association believes that mental health parity would be too costly for small businesses. Baird urged those at the hearing to look for the NFIB logo at small businesses, and to educate businessmen that they may be paying dues to an association with a shortsighted view of the cost-effectiveness of funding mental health care. Those interested in learning about the progress of the parity bill can get information at www.equitycampaign.net.

What Can I Do To Get Equal Mental Health Insurance Coverage?

Take Action: Use the toll-free Parity Hotline, 1-866-parity4 (1-866-727-4894), to call your state's senators to urge cosponsorship of the mental health parity legislation. (The Parity Hotline reaches the Capitol switchboard, which can connect callers to their members of Congress.) Also, write to your senators (see attached letter).

Targets: All members of the Senate.

Message for Non-Cosponsors: "I am calling to ask that the senator cosponsor the Mental Health Parity Act, S. 558. Parity is a fair and affordable solution to insurance discrimination that will save lives and families."

Message for Cosponsors: "I am calling to thank the senator for having cosponsored the Mental Health Parity Act, S. 558. Parity is a fair and affordable solution to insurance discrimination that will save lives and families."

Sponsor: Sen Domenici, Pete V. [NM]
Cosponsors:
Sen Akaka, Daniel K. [HI] - 2/12/2007
Sen Alexander, Lamar [TN] - 2/14/2007
Sen Bennett, Robert F. [UT] - 3/8/2007
Sen Biden, Joseph R., Jr. [DE] - 2/12/2007
Sen Bingaman, Jeff [NM] - 2/14/2007
Sen Boxer, Barbara [CA] - 2/12/2007
Sen Brown, Sherrod [OH] - 2/12/2007
Sen Cantwell, Maria [WA] - 2/12/2007
Sen Cardin, Benjamin L. [MD] - 2/12/2007
Sen Carper, Thomas R. [DE] - 3/8/2007
Sen Clinton, Hillary Rodham [NY] - 2/15/2007
Sen Cochran, Thad [MS] - 3/12/2007
Sen Coleman, Norm [MN] - 2/12/2007
Sen Collins, Susan M. [ME] - 2/12/2007
Sen Conrad, Kent [ND] - 2/15/2007
Sen Durbin, Richard [IL] - 2/15/2007
Sen Enzi, Michael B. [WY] - 2/12/2007
Sen Feingold, Russell D. [WI] - 2/12/2007
Sen Graham, Lindsey [SC] - 2/12/2007
Sen Harkin, Tom [IA] - 2/15/2007
Sen Hatch, Orrin G. [UT] - 2/12/2007
Sen Inouye, Daniel K. [HI] - 2/15/2007
Sen Johnson, Tim [SD] - 2/28/2007
Sen Kennedy, Edward M. [MA] - 2/12/2007
Sen Kerry, John F. [MA] - 3/8/2007
Sen Klobuchar, Amy [MN] - 2/15/2007
Sen Lautenberg, Frank R. [NJ] - 2/12/2007
Sen Levin, Carl [MI] - 2/28/2007
Sen Lieberman, Joseph I. [CT] - 3/20/2007
Sen Lugar, Richard G. [IN] - 2/27/2007
Sen McCaskill, Claire [MO] - 2/14/2007
Sen Murkowski, Lisa [AK] - 2/12/2007
Sen Nelson, Bill [FL] - 3/7/2007
Sen Nelson, E. Benjamin [NE] - 2/12/2007
Sen Roberts, Pat [KS] - 2/12/2007
Sen Salazar, Ken [CO] - 2/13/2007
Sen Schumer, Charles E. [NY] - 3/1/2007
Sen Smith, Gordon H. [OR] - 2/12/2007
Sen Snowe, Olympia J. [ME] - 2/12/2007
Sen Stabenow, Debbie [MI] - 2/12/2007
Sen Warner, John [VA] - 2/12/2007
Sen Whitehouse, Sheldon [RI] - 3/20/2007

Background: The Mental Health Parity Act, S. 558, expands the Mental Health Parity Act of 1996 by prohibiting group health plans from imposing treatment or financial limitations on mental health benefits that are different from those applied to medical/surgical services. The legislation applies only to group health plans already providing mental health benefits and exempts plans sponsored by small businesses of under 50 employees.

Resources: Fact sheets on parity, and the roster of over 100 organizations backing S. 558, may be found at http://www.mhlg.org/page18.html.

Sample Letter:

The Honorable [full name]
United States Senate
Washington, DC 20510

Dear Senator [last name]:

I am writing to ask that you cosponsor S. 558, the Mental Health Parity Act, that was introduced by Senators Domenici, Kennedy and Enzi. This bipartisan legislation can make a real difference for patients, many of whom now face higher coinsurance and strict limits on the days of care to help them with their mental disorder.

Mental health disorders are the second leading cause of disability and premature death in the United States. Yet, every day families with "good health coverage" discover that their loved ones cannot get the care they need, because their employer-provided health insurance sets arbitrary, one-size-fits-all limits on mental health treatment, but imposes no such limits on other medical and surgical benefits.

These barriers to medically necessary mental health treatment inflict enormous harm on American families...and on our economy. These discriminatory practices often cause mental health disorders to go untreated and worsen. Tragically, this lack of care leads all too often to unemployment, broken homes, school failure, and even suicide. Untreated mental health disorders also costs our economy about $80 billion each year – in lost productivity, sick leave and unemployment.

This legislation, approved by the HELP Committee on Feb. 14, would require parity between mental health benefits and the benefits provided to treat any other illness or injury. This simple, fair step will save lives and families. As studies have shown, mental health parity legislation will not lead to a significant increase in insurance premiums or in the number of uninsured Americans. But the costs of not enacting parity are high, and will fall most heavily on taxpayer-funded public programs, our economy, and the well-being of American families and their communities.

Please cosponsor S. 558 and make its passage a top priority. I appreciate your consideration of my concerns and look forward to hearing from you.

Sincerely,

Mindfulness Training

(continued from page 11)

We believe that it is the avoidance of primary emotional experience such as fear and sadness that results in the chronic secondary emotional symptoms of anxiety and depression and we thus target it in our treatment (c.f., Newman et al., 2004). This avoidance of primary emotions such as fear as opposed to anxiety and sadness and as opposed to depression results in the failure to base one's responses on the reality of today rather than a feared yesterday or tomorrow. Indeed, Dr. Leslie Greenberg, a clinical psychologist, has proposed that the emotional processing theory can be extended to include not just the fear structure that must be modified to reduce anxiety, but a more broadly conceptualized, "emotion structure" (Safran & Greenberg, 1991). This emotion structure, with its maladaptive stimulus, response, and meaning elements, can guide a therapist in successfully modifying such maladaptive elements as well as associated emotional responses. Such responses would include those that are marked not just by fear but also other negative emotions such as sadness, disgust, and anger.

We think that our willingness to target more than the primary symptoms of OCD in treatment is why we have a history of treating previously refractory cases with a success rate of over 70% (using the criteria for success typical in the field). Described below are the two cases who responded well to our integrative MBBT approach to treatment.

The first patient (T.A.) had been seen by more than three separate clinicians who utilized other behavior modalities, but who were not experts in treatment of OCD or medications. T.A. was diagnosed with primary OCD and co-morbid PTSD, as well as schizotypal personality traits with overvalued ideation. T.A. also had somatoform symptoms that manifested as the inability to move both his limbs and to get out of bed. He exhibited a severe motor rigidity while walking and resembled an expressionless robot. His results are reported in Table 1 and show a substantial reduction of all symptom types. As well, his affect after treatment was appropriate, expressive, and variable.

The second patient (J.P.) had primary OCD but was not fully diagnosed with PTSD because such elements as nightmares and intrusive images of her mother dying (three years prior to treatment) were not present. However, she attempted to avoid words associated with death and dying. When such words were unavoidable, she replaced those "bad feelings" and associations with both overt and covert compulsions in order to neutralize her anxiety. Stimuli that evoked her compulsions also included specific numbers and would prompt her to review, repeat or avoid until she felt "right." She also exhibited several symptoms of social anxiety disorder, specific fears, and depression that substantially interfered with functioning. Hospitalization was discussed but ultimately not utilized, and she responded to a purely outpatient intervention. Table 2 also reveals her significant symptom reduction in response to MBBT.

Data Scores for T.A. (first subject)

Date	*06/13/06*	*06/29/06*	*Improvement*
Yale Brown Obsessive Compulsive Scale	*37*	*7*	*81%*
Obsessive Compulsive Inventory-Short Version	*44*	*10*	*77%*
Obsessive Compulsive Inventory (Frequency / Distress)	*116 / 115*	*10 / 12*	*91% / 90%*
Fear Survey Schedule	*227*	*68*	*70%*
Willoughby Questionnaire	*66*	*35*	*47%*
Fixity of Beliefs Scale	*8*	*4*	*50%*
NIMH Global OCD Scale	*10-12*	*6-8*	*2 grades*
Hamilton Depression	*24*	*5*	*79%*
Hamilton Anxiety	*22*	*3*	*86%*
Global Assessment Functioning Scale	*40-31*	*80-71*	*4 grades*
Brown Assessment of Beliefs Scale	*6*	*0*	*100%*

Data scores for J.P.(second subject)

Date	*09/15/06*	*10/08/06*	*Improvement*
Yale Brown Obsessive Compulsive Scale	*36*	*8*	*78*
Obsessive Compulsive Inventory-Short Version	*41*	*10*	*76*
Obsessive-Compulsive Inventory (Frequency / Distress)	*112 / 112*	*27 / 21*	*76% / 81%*
Fear Survey Schedule	*270*	*108*	*60*
Willoughby Questionnaire	*72*	*25*	*65*
Fixity of Beliefs Scale	*16*	*3*	*81*
NIMH Global OCD Scale	*10-12*	*6-8*	*2 grades*
Hamilton Depression	*23*	*0*	*100*
Hamilton Anxiety	*19*	*0*	*100*
Global Assessment Functioning Scale	*40-31*	*90-81*	*5 grades*

Room Monitors Are Needed for the 14th Annual OCF Conference

July 20 – 22, 2007

Please Contact Mary Grande at (203) 401-2070 x11 or grande@ocfoundation.org

Bulletin Board

(continued from page 2)

this unique workshop, Dr. Wagner will cover anxiety-related topics that are not typically covered in depth in any single workshop. It is designed for clinicians and school professionals with at least intermediate experience with CBT, or those who have attended Dr. Wagner's previous workshops. The focus is on conceptualizing, strategizing and intervening with hard-to-treat and unusual symptoms, co-morbidities, overlapping symptom dimensions, and crisis-prone situations. Step-by-step clinical decision-making, selection and application of strategies through different phases of treatment will be reviewed. This workshop will integrate the science and the art of CBT, including the subtleties and the nuances of delivery and the complexities of the therapeutic alliance. Case discussions, video clips, "clinical pearls" and structured exercises will be woven through the workshop.

For more information or to register, please visit www.Cape.org or call 888-394-9293.

Are You a Packrat, Hoarder, Clutterer?

RESEARCH STUDY OFFERING FREE MEDICATION TREATMENT

The University of California at San Diego OCD Program is looking for people who have problems with hoarding, saving, or clutter to take part in a study that is providing:

- 12 weeks free medication treatment
- Brain imaging scans
- Diagnostic Evaluation
- Neuropsychological Evaluation

For more information call (858) 642-3472

OCD Research at the U.S.-Mexico Border

The College of Health Sciences at the University of Texas at El Paso is conducting research about OCD in relation to culture and ethnicity.
Are you:

- Suffering from OCD (diagnosed or not)
- Of Mexican or Mexican-American background
- Over age 18
- Living in the El Paso, TX - Ciudad Juarez, Chih. (Mexico) border area

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Bulletin Board

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We have a one-time confidential interview that lasts about 40-60 minutes. We will ask you about quality of life, symptoms, availability of treatment, culture, etc. We provide a $25 gift certificate in compensation for your time.

Contact Oriana Perez at (915) 747-8317 or at operez@utep.edu, or Dr. Tom Olson at (915) 747-7246 or at tolson@utep.edu to schedule an interview.

Does Your Child Need to do Things Over and Over Again? Does He or She Have Recurrent and Bothersome Thoughts or Images?

Does your child repeatedly check or arrange things, have to wash his/her hands repeatedly, or maintain a particular order? Do unpleasant thoughts repeatedly enter your child's mind such as concerns with germs or dirt or needing to arrange things just so?

If this sounds familiar, your child may have a treatable problem called Obsessive Compulsive Disorder (OCD). Past research has found that a form of cognitive therapy, called Exposure and Response Prevention Therapy, is helpful in as many as 85% of children with OCD. We are interested in determining if adding a medication called D-Cycloserine improves the effectiveness of Exposure and Response Prevention Therapy in children with OCD.

You must be between the ages of 8 and 17 years old to be eligible for this study. If you are eligible to participate in this study, you will be randomly assigned, that is by chance as in the "flip of a coin," to receive either the study medication (D-Cycloserine) or a sugar pill in addition to being seen in therapy. The therapy will be held weekly (90 minutes each session) for 8 weeks. There will also be 3 psychiatric evaluations that take place. Two of these evaluations will be comprehensive and take about 3 hours each (immediately before and after treatment). During each of these, your child will have a small amount of blood withdrawn for lab tests. One evaluation will be short and take place in the middle of treatment. Study medication, treatment, laboratory tests, and the evaluations will be provided at no charge. Participants will also receive financial compensation for their time. If interested, please call Dr. Eric Storch of the University of Florida at (352) 392-3613.

Autism Spectrum Disorder and Obsessive Compulsive Disorder Study

If your child or teen (ages 7-17) is suffering from Obsessive-Compulsive Disorder (OCD) he or she may be able to participate in a research study at the National Institute of Mental Health (NIMH). We are investigating the medication riluzole.

Children and adolescents with 1) both Autism Spectrum Disorder and OCD or 2) a primary diagnosis of OCD may be eligible. Participants will be randomized to either riluzole or placebo (pill with no active ingredient) for 12 weeks. At the end of 12 weeks, all participants will have the option of taking riluzole (no chance of placebo). A comprehensive psychiatric and medical evaluation and follow-up visits approximately monthly for 6 months, and at 9 and 12 months, are included. There is no cost to participate. Travel assistance may be provided.

For further information please call 301-435-6652 or 301-496-5323 (Lorraine Lougee, LCSW-C) (or email OCDNIMH@intra.nimh.nih.gov .

National Institute of Mental Health, National Institutes of Health, Department of Health and Human Services.

OCD and Hoarding Study

The Institute of Living in Hartford, CT and The Boston University School of Social Work are conducting research to understand the features of obsessive compulsive disorder and compulsive hoarding. The study compares people with hoarding problems to those who have obsessive compulsive disorder (OCD). It is not necessary for participants to have hoarding problems or clutter to participate. The researchers hope to learn more about why hoarding and obsessive compulsive symptoms develop, how these problems are related to other psychiatric disorders and how best to assess these problems. This information may be helpful for identifying effective treatments in the future.

Researchers are looking for people age 18 or older who have (1) problems with excessive clutter or (2) obsessive compulsive disorder and, (3) live within forty minutes of the greater Hartford or Boston areas. The study consists of a 4-hour diagnostic interview about anxiety and mood symptoms followed by a 4-hour interview about clutter and acquiring. These interviews take place at the clinics.

Additionally, the study will include a 1-hour visit to the participant's home where the participant will take part in an experimental task about removing clutter and another task about acquiring new items. Participants will also have a chance to take part in a discarding and acquisition task. Participants will be paid $20/hr for their time and can make up to $180.

If you are interested in participating and have any questions, please contact Jessica Rasmussen, B.A. at Boston University at (617) 358-4213 or (617) 353-9610, or Kristin Fitch, B.A. at The Institute of Living in Hartford, CT at (860) 545-7574.

Do you suffer from obsessive compulsive disorder?

PARTICIPANTS WANTED

Research Study on the Effectiveness of Duloxetine (Cymbalta) In Treating Obsessive Compulsive Disorder

Dr. Darin Dougherty of the Massachusetts General Hospital OCD Clinic and Research Unit is conducting a research study on the use of duloxetine (Cymbalta) to reduce the symptoms associated with obsessive compulsive disorder (OCD). If you have OCD, you may be eligible to participate in this study.

To be eligible you must:

- be between 18-65 years old.
- live within 1 hour of Boston .
- be able to participate for 17 weeks.
- not be pregnant or breastfeeding.

If you are interested in this study and believe you are eligible, please contact Mariko Jameson at (617) 726-9281.

Drug Study for Hair Pullers

Do you pull your hair? Is it causing problems? Does it feel out of control? We are currently seeking volunteers for a drug study for hair pulling. Participation is confidential and requires visits to our Minneapolis, MN site. Please email or call if you would like more information.

Brian Odlaug, Reseach Coordinator, Department of Psychiatry, University of Minnesota, (612) 627-4363 (confidential line), email: odla0019@umn.edu.
Jon Grant, M.D., Department of Psychiatry, University of Minnesota, (612) 273-9736 (confidential line), email: grant045@umn.edu.

Compliance with Solicitation Regulations

The Obsessive Compulsive Foundation, Inc. ("OCF") is a Connecticut not-for-profit corporation. Its mission is to educate the public and professional communities about Obsessive Compulsive Disorder ("OCD") and related disorders; to educate and train mental health professionals in the latest treatments for OCD and related disorders; to provide assistance to individuals with OCD and related disorders and their family and friends; and to support research into the causes and effective treatment of OCD and related disorders. The OCF's principal place of business is 676 State Street, New Haven, Connecticut 06511-6508. The information enclosed herein describes one or more of the OCF's activities. Your gift is tax deductible as a charitable contribution. Contributions received by OCF do not inure to the benefit of its officers, directors or any specific individual.

A copy of OCF's most recent financial report is available upon request and may be obtained at no cost by writing to OCF at P.O. Box 9573, New Haven, Connecticut 06535-0573 or by contacting its Executive Director at (203) 401-2074. If you are a resident of one of the following states, you may obtain information directly as follows: **Florida**: A COPY OF THE OFFICIAL REGISTRATION AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE FLORIDA DIVISION OF CONSUMER SERVICES BY CALLING TOLL FREE WITHIN THE STATE (800) 435-7352, OR (850) 488-2221 IF CALLING FROM OUTSIDE FLORIDA. OCF'S REGISTRATION NUMBER IN FLORIDA IS CH8507. **Maryland**: A copy of the documents and information submitted by the OCF pursuant to the Maryland Charitable Solicitations Act are available for the cost of copies and postage from the Secretary of State, State House, Annapolis, MD 21401, Telephone (401) 974-5534. OCF's registration number in Maryland is 5015. **Mississippi**: The official registration and financial information of OCF may be obtained from the Mississippi Secretary of State's office by calling (888) 236-6167. OCF's registration number in Mississippi is C1143. **New Jersey**: INFORMATION FILED WITH THE ATTORNEY GENERAL CONCERNING THIS CHARITABLE SOLICITATION MAY BE OBTAINED FROM THE ATTORNEY GENERAL OF THE STATE OF NEW JERSEY BY CALLING (973) 504-6215. OCF'S REGISTRATION NUMBER IN NEW JERSEY IS CH1461800. **New York: A copy of the most recent annual report filed by OCF with the New York Secretary of State may be obtained by writing to Charities Bureau, 120 Broadway, New York, NY 10271, Telephone (518) 486-9797. OCF's registration number in New York is 66211. North Carolina: A COPY OF THE LICENSE TO SOLICIT CHARITABLE CONTRIBUTIONS AS A CHARITABLE ORGANIZATION OR SPONSOR AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE DEPARTMENT OF HUMAN RESOURCES, SOLICITATION LICENSING BRANCH, BY CALLING (919) 733-4510. OCF'S REGISTRATION NUMBER IN NORTH CAROLINA IS SL002059. Pennsylvania**: A copy of the official registration and financial information may be obtained from the Pennsylvania Department of State by calling toll free, within Pennsylvania, (800) 732-0999. OCF's registration number in Pennsylvania is 15687. **Virginia**: A copy of the OCF's most recent financial statement is available upon request from the State Division of Consumer Affairs in the Department of Agriculture and Consumer Services. **Washington**: Additional financial disclosure information may be obtained by contacting the Secretary of State toll free, within Washington, at (800) 332-GIVE. OCF's registration number in Washington is 6363. **West Virginia**: West Virginia residents may obtain a summary of the registration and financial documents from the Secretary of State, State Capitol, Charleston, West Virginia 25305.

REGISTRATION WITH A STATE AGENCY DOES NOT CONSITUTE OR IMPLY ENDORSEMENT, APPROVAL OR RECOMMENDATION BY THAT STATE.

THE OCF DOES NOT HAVE A PROFESSIONAL SOLICITOR. ONE HUNDRED PERCENT 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.

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