

Someone I Care About Is Not Dealing With His OCD: What Can I Do About It?

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Some people visit their doctor at the first sign of a physical symptom, others may wait till the symptoms interfere with their daily routine. Then there are a group of sufferers who seldom avail themselves of professional help, even when the problem negatively affects their life and the lives of their family. This last group can be characterized as "recovery avoiders," or RAs. Recovery avoidance is difficult for most people to understand and there are few resources available to help understand it. The purpose of this article is to provide some information on recovery avoidance and discuss resources available to families and friends of OCD sufferers who avoid recovery.

What is Recovery Avoidance?

Recovery avoidance can be associated with almost any type of problem, from someone who has lung disease and doesn't stop smoking to someone with manic-depressive illness who refuses to maintain Lithium treatment. In all cases, a person's behavior is incompatible with the pursuit of health or well-being. RAs usually downplay the severity of the problem or do not acknowledge having a problem at all. They take few, if any, steps on their own to find help or to learn about their disorder. Family members and friends are usually working much harder than the RA to do something about the problem. If treatment is sought, it is only because others have pressured the RAs to go. And they do not fully participate once they're in treatment.

We do not know exactly what portion of OCD sufferers are RAs. However, it is probably a substantial number. Studies indicate only a minority of OCD sufferers has received appropriate treatment. While

there are other reasons why people do not obtain professional help (e.g., lack of information, too few qualified providers, etc.), our clinical experience suggests recovery avoidance is one of the major reasons why so many cases of OCD remain undertreated or untreated altogether.

It is natural for those who do not have OCD to wonder why an RA would not do everything possible to overcome this disabling disorder. However, it is important to remember RAs do not fully recognize the self-defeating nature of their behavior. They are usually responding out of habit and do not know what else to do. It is easier to empathize with an RA if we recognize most of us have avoided dealing with some problem or another in our lives. Putting off addressing a problem is very common. The consequences of not dealing with OCD, however, can be devastating for those who suffer from this disorder and for their loved ones as well.

The effect on family and friends can lead them to conclude the RA is lazy, spoiled, unmotivated, or selfish, or that s/he must like being ill. Judgments like these may feel justified to someone who does not understand recovery avoidance, but demeaning labels tell us nothing about why RAs behave the way they do. Such harsh judgments, expressed or unexpressed, do not spur the OCD sufferer to change, nor do they help the family heal. A useful explanation of recovery avoidance should make sense of the individual's behavior and provide clues for how to improve the situation.

Why Don't Some OCD Sufferers Deal with Their Disorder?

There may be other factors involved, but we believe there are two main reasons why some people avoid recovery. The first reason is fear. Those who do not have OCD often fail to appreciate the level of

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From the President

Dear Friends,

We announced the winners of the 2002 OCF Research Awards in late June. Just prior to the announcement, the board of directors approved six projects from the 22 that were submitted for consideration.

While excellent scientific merit and study design are always important, this year we were seeking studies that would reveal more about the difference and similarities among the subtypes of OCD; or studies that would quantify the effectiveness of current OCD treatment; and/or those that would lead to the discovery of more effective treatments.

We believe that the six research studies that were selected met the criteria. And I am delighted to introduce the 2002 projects and their principal investigators:

* "Cognitive-Behavior Therapy for Comorbid OCD and Major Depression," Jonathan S. Abramowitz, Ph.D., assistant professor of Psychology, Mayo Clinic/Mayo Medical School, Rochester, MN;

* "Home-Based versus Office-Based Behavioral Treatment of Obsessive Compulsive Disorder," Martin Antony, Ph.D., associate professor, McMaster

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BULLETIN BOARD

Do you suffer from Obsessive-Compulsive Disorder and live within commuting distance of New York City?

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

Brain Imaging Studies in Individuals with OCD

Using pilot data obtained from an Obsessive-Compulsive Foundation Research Award grant as the basis for his application, Dr. Philip Szeszko from Hillside Hospital in New York received a five year grant from the National Institute of Mental Health in May, 2001 to conduct brain imaging studies in individuals with OCD. His research will use imaging modalities such as diffusion tensor imaging (DTI) and functional magnetic resonance imaging (fMRI) to better understand which brain regions play a role in the neurobiology of OCD. DTI is a relatively new imaging modality that permits the characterization of white (connecting) matter in the brain and may be considered an index of how brain regions are interconnected and able to communicate with each other. Functional magnetic resonance imaging (fMRI) is a noninvasive technique that can monitor brain activity during the performance of neuropsychological tasks. Study participants will also have comprehensive neuropsychological, clinical and diagnostic assessments. It is hoped that ultimately the information learned from these studies will be able to inform treatment strategies.

Are You Experiencing:

- persistent repetitive thoughts
- repetitive senseless actions
- repeated washing, counting or rituals
- contamination fears
- hoarding

You may be eligible to participate in a research study funded by the National Institute of Mental Health. This study uses magnetic resonance imaging to identify brain circuits that may play a role in causing Obsessive Compulsive Disorder, but does not provide treatment. You will be reimbursed for your time and sessions are scheduled at your convenience.

For a free confidential telephone screening to determine study eligibility, please call (718) or (516) 470-8157.

HILLSIDE HOSPITAL North Shore – Long Island Jewish Health System.

A UCLA Research Study of Obsessive Compulsive Disorder

Do you experience recurrent time-consuming obsessions or compulsions, persistent ideas, thoughts, impulses, or images such as fear of contamination? Do you practice repetitive behaviors such as excessive handwashing, cleaning, and checking? If you are over the age of 18 and are not currently attending behavioral therapy, and experience one or more of these symptoms, you are invited to participate in a research project studying an investigational medication for Obsessive Compulsive Disorder at the UCLA Neuropsychiatric Institute.

Participants in the study will be eligible for an extensive psychiatric evaluation that will be provided at no cost to those who qualify. You must not be in behavioral therapy. There will be monetary compensation for participants' time.

Study conducted by Dr. Alexander Bystritsky, Department of Psychiatry, UCLA.

If you or someone you care about is interested in participating, please call (310) 206-5133 or (310) 794-1038.

Family Involvement in the Group Treatment of Hoarding/Saving Behavior

The Bio-Behavioral Institute of Great Neck, New York, is currently recruiting individuals who engage in compulsive hoarding and their respective family members to participate in a treatment study investigating the effects of family involvement in treatment outcome. Qualified participants and their family members will engage in a 16-week treatment group consisting of psychoeducation and cognitive and behavioral treatment. If you are interested, please call us at (516) 487-7116 to learn more about this study.

Study on Skin Picking

The Bio-Behavioral Institute of Great Neck, New York, is currently conducting a study investigating skin picking behavior as a symptom of various disorders including the obsessive compulsive spectrum. We are interested in gathering information about demographic variables, situational and emotional triggers, co-morbidity, and family variables. As a study participant, you will receive a screening and evaluation at no cost to you.

If you are over the age of 18, please call us at (516) 487-7116 to learn more about this study.

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

OCD NEWSLETTER

The OCD Newsletter is published six times a year.

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

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

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An Interview with the Staff at The Obsessive Compulsive Disorder Institute at McLean Hospital

The following interview on the Obsessive Compulsive Disorder Institute at McLean Hospital in Belmont, MA, includes responses from Michael A. Jenike, M.D., the director of OCDI, Deborah Osgood-Hynes, Ph.D., OCDI's chief psychologist and Diane Davey, R.N., M.B.A., the Institute's program director.

NEWSLETTER: What inspired you to start the OCD Institute?

JENIKE: I started working with OCD patients in the late 1970s, and in the early 1980s my colleagues and I noted that some patients' OCD symptoms did not improve despite state of the art



Michael A. Jenike, M.D.

behavior therapy and medications. It seemed that their lives were on hold and consisted of persistent suffering and disability. At that time, I approached our hospital administration to see if they were interested in a residential OCD facility. After about ten minutes of thought, they could not figure how this could be a money-making proposition, so the idea was put to rest. About six years ago, I mentioned the need for a residential facility to the father of one of our patients, and he offered to give some initial funding to help get the facility started. It turned out that McLean Hospital had an open building and was interested in an OCD residential unit. This allowed us to set up the OCD Institute from the ground up.

NEWSLETTER: What did you want to accomplish by setting up the OCD Institute?

JENIKE: We thought that if we could offer more intensive daily behavior therapy that patients might get better. We wanted a facility where we could help the patients who could not function due to persistent and overwhelming rituals that did not respond to conventional treatments.

NEWSLETTER: Why did you set up the Institute as a residential treatment center? What led you to believe that OCD could be treated successfully by intensive (almost 24-hour a day) cognitive behavior therapy?

JENIKE AND OSGOOD-HYNES: We did not know if this was true or not, but we felt it was worth a try. While many people are able to do behavior therapy on an outpa-

tient basis, some could not. We felt that those who were motivated but could not do the behavior therapy entirely on their own might be able to get some benefit if given the opportunity to have therapists do the exposure and response prevention tasks with them intensively several times a day every day.

NEWSLETTER: You're a psychiatrist. What led you to the idea of establishing an intensive treatment program for OCD where medication and cognitive behavior therapy play equal roles? Was it research? Was it clinical experience?

JENIKE: It was our clinical experience that patients did best with a combination of medication and behavior therapy and that either treatment alone was generally less effective.

NEWSLETTER: When you first started practicing psychiatry, OCD was considered a very rare, untreatable disease. What attracted you to it?



The OCD Institute at McLean Hospital

JENIKE: My early years in psychiatry were spent running the inpatient service at Massachusetts General Hospital and also co-directing the Memory Disorders Service where we assessed and managed patients with illnesses, where individuals lost their memories and cognitive abilities, such as, Alzheimer's disease. I first met some OCD patients when I was a resident psychiatrist. I was told that they usually did not get better and that years of psychotherapy were necessary. I found the patients fascinating, but they had a quality that seemed quite unique – their symptoms consisted of pure suffering. The patients were for the most part very nice and competent people, but they were tormented by obsessions and rituals that they knew did not make sense (usually), but nonetheless they felt like they were unwilling slaves to the OCD.

One patient with very severe OCD also

had panic attacks; and, with my embryonic knowledge of psychiatry, I knew that drugs called MAO Inhibitors could help panic attacks. I tried this patient on a MAO Inhibitor; and she had a dramatic improvement not only in her panic attacks but also in her OCD. This led me to prescribe drugs for other OCD patients; and many did wonderfully well. The supposedly untreatable OCD got better. I eventually found an experienced behavior therapist willing to help treat OCD patients. Working together, we used both medication and behavior therapy. It became clear to us that the combination treatment worked better for most patients than either alone.



Deb Osgood-Hynes, Psy.D.
Chief Psychologist

NEWSLETTER: There were intensive treatment programs before you opened the Institute, but none of them were open-ended residential programs only for OCD. Why did you decide that you needed a residential setting devoted exclusively to people with OCD?

JENIKE: In my opinion, the treatment of OCD is quite unique. Many severely ill OCD patients had been hospitalized in general psychiatric units; and most were not helped or even got worse. Psychiatric hospitalization is a huge blow to one's self esteem and should only be considered when other treatments have failed. If an OCD patient is put into a general psychiatric unit that does not know how to treat OCD or is not behaviorally oriented, patients feel worse and even more like a failure.

NEWSLETTER: Can you describe OCDI's treatment program? Is there one set treatment program or is there a unique treatment plan developed for each patient?

JENIKE AND OSGOOD-HYNES: Our overall philosophy is a cognitive behavioral approach, but each person has a treatment plan tailored to his or her particular symptoms. There are groups at the OCD Institute that most patients attend which focus on symptom specific issues as well as general cognitive and behavioral coping strategies. And, each patient also has at least three hours of individually tailored treatment per day.

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fear an OCD sufferer experiences. The fear may not be based on realistic concerns, but that does not matter. What a person perceives determines the level of fear. The very thought of giving up the avoidance and compulsions can be overwhelming to an OCD sufferer. These counterproductive ways of coping create an illusion of safety and control that is not always easily surrendered. Nobody wants to be disabled, but some OCD sufferers are terrified of getting better.

The second reason some people avoid recovery is what we term incentive deficits. Incentives are things that push a person to act. Money, for example, motivates people to go to work. Money is an incentive. Human behavior is influenced largely by incentives, and recovery behavior is no exception. You go to the doctor because you want to get rid of something negative (e.g., unpleasant symptoms) or because you want something positive the disorder is keeping you from obtaining (e.g., a job, food, relationships, pleasurable activities, etc.). In order to be willing to endure the discomfort of treatment and generate the effort necessary to pursue recovery, a person must have sufficient incentive. Incentive is different from motivation, which is characterized as desire. For example, one may desire (be motivated) to lose weight, but without sufficient incentive to maintain behaviors that need to be performed to accomplish the weight loss, the goal will not be accomplished. Desire alone is not sufficient for behavior change; wanting something to occur is not the same as doing what needs to be done. Incentives increase motivation and fuel action.

Some OCD sufferers do not fully recognize the negative consequences of their disorder. Others do not sufficiently recognize the positive things in life they are missing because of their OCD. Still others no longer believe life's pleasures are possible for them. All of these individuals may desire to get better. A few may have even tried therapy. But they are unable to do what needs to be done to maintain the behaviors that will accomplish their goal. These individuals have incentive deficits.

We can summarize the relationship between fear, incentive, and recovery behavior with a general proposition: All things being equal, a person will not seek recovery unless the incentive to get better is stronger than the fear of getting better.

Therefore, an RA's behavior is unlikely to change unless the fear goes down, the

incentive goes up, or both. The significance of this understanding of recovery avoidance is that both fear and incentive can be modified to assist the RA. Remember, a useful explanation for problem behavior should provide clues for how to change the behavior. In the next sections, we discuss how families and friends positively and negatively influence both the fear and incentive of OCD sufferers.



C. Alec Pollard, Ph.D.

Heidi J. Pollard, RN, MSN

How Do Family and Friends Unintentionally Contribute to Recovery Avoidance?

Before discussing this topic, it is important to address the sometimes overwhelming guilt and shame experienced by many family members, especially parents. Some parents worry that the OCD is a sign of their inadequacy as a parent ("Was there something I could have done to prevent this?"). Please be clear. There is no convincing evidence that the behavior of parents or any other family member causes OCD. Too many parents are tortured by misguided guilt and shame, blaming themselves for something over which they had no control. This level of self-criticism and overassumption of responsibility is harmful for everyone involved. Guilt and shame only complicate the already challenging task of dealing with OCD.

Does this mean families have no responsibility? Certainly not. Although families don't cause OCD, family behavior can influence how a person deals with the OCD. And how people deal with OCD can determine whether or not they get better. It is pointless to ask, "Did I cause the OCD?" It is useful, however, to ask, "How can I support recovery?"

In order to understand how to support recovery, it is helpful to know what not to do and why. There are two ways in which family members and friends unintentionally contribute to recovery avoidance. The first we call "minimizing" because the

person's behavior minimizes the severity of the problem. The assumption underlying minimizing behavior is that the OCD sufferer should be able to change simply because of something the family member or friend says or does. Examples of this behavior include nagging, prodding, lecturing, yelling, threatening, pressuring, criticizing, name calling, shaming, etc. These tactics rarely achieve the desired effect. In fact, they are usually met with increased resistance and anger. The implicit message of minimizing is "you can and should change now," a pressure which may only produce more fear and defensiveness. Remember, fear is one of the factors behind recovery avoidance. The minimizing behavior of loved ones risks generating more fear, which can make an RA even less likely to seek treatment.

The second way to contribute to recovery avoidance is called "accommodating," also known by the more popular term "enabling." Accommodating is engaging in abnormal behavior (i.e., behaving differently than you would around someone who does not have OCD) in order to help OCD sufferers avoid exposure to obsessive triggers or assist them to perform compulsions. Parents, for example, who have trouble witnessing their children experience frustration or failure, may do their children's homework for them. Other examples include family and friends doing chores the person with OCD should be doing, repeatedly providing reassurance, complying with irrational demands, and unconditionally supporting an adult OCD sufferer financially. Accommodation sends the opposite message of that implied by minimizing. It says to the OCD sufferer, "you are incapable of doing these behaviors and we must do them for you." Accommodation promotes recovery avoidance because it protects OCD sufferers from the natural consequences of their OCD and, thus, reduces the incentive necessary to actively pursue recovery.

How Can Family and Friends Support Recovery?

The goal is to support recovery from OCD. That means promoting the recovery of everyone affected by the disorder, not just that of the OCD sufferer. In order to accomplish this goal, family and friends must at times perform a balancing act. They must try to be understanding and empathic of the OCD sufferer's plight, while gently but firmly refusing to participate in the OCD sufferer's avoidance. They must stop trying to control the OCD sufferer's behavior and

What Can I Do About It?

start focusing on what they can control – their own behavior. Here are a few things families and friends of an RA can do:

1. Learn as much as you can about OCD and its treatment.
2. Share what you learn with the OCD sufferer and with other family members and friends who are interested.
3. Express your concerns to the OCD sufferer about the OCD and the impact you feel it has had on his life and your own. And communicate your hope that s/he will seek help.

Also, inform the OCD sufferer of any changes you will be making in how you deal with the OCD. Include other family members in the discussion if they are willing to participate. This should not be confused with nagging or lecturing. The type of discussion we are suggesting is respectfully prearranged with the OCD sufferer. It is not initiated spontaneously out of anger and repeated over and over. And it does not involve arguing. Make your point, but do not argue. You are there to express your concerns and perhaps to set some limits, but not to change anybody's mind.

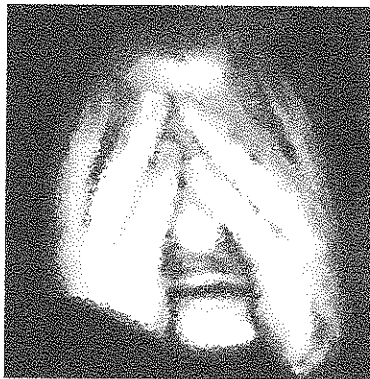
Your well-being and that of the OCD sufferer do not depend on convincing him/her of anything right now.

4. Normalize your life as much as possible. By this we mean take steps to reduce the impact of the OCD on your life and any other participating family members and friends. This does not require the cooperation of the OCD sufferer. It does require that you stop accommodating the OCD. A family impaired by the stress of accommodating OCD is not in a state to truly help the OCD sufferer. They must first take care of their own health.

We do not suggest these steps are easy to implement. On the contrary, disengaging from minimizing and accommodating can be extremely difficult and stressful. You will be trying to change behaviors that may have become strong habits. These changes are likely to make you feel guilty or fearful ("Am I doing the right thing?"). It will not be easy to witness your loved one experience the distress of being less protected from the consequences of OCD. And you will need to be prepared to deal with the OCD sufferer's negative reactions to the changes in your behavior.

Some people have tried implementing steps like these but were unable to follow

through. It can be extremely difficult to do without help. When the OCD sufferer is participating in treatment, family and friends often receive guidance from the patient's mental health professional. In this instance, changes in the family's accommodation of the OCD are typically made gradually in collaboration with the therapist. Accommodation is withdrawn in a way that is sensitive to the patient's level of progress. However, an RA often does not agree that changes are necessary and s/he is usually not in therapy. Without a therapist involved, family and friends have to decide for themselves at what pace they are going to withdraw accommodation. Fortunately, there are some resources available to help them.



What Help Is Available for the Family and Friends of a Recovery Avoider?

There are numerous resources to help family and friends learn about OCD and its treatment. The OC Foundation website (www.ocfoundation.org) offers a great deal of useful information. It is well worth the investment in time to browse the many wonderful and helpful sections on this website. The on-line bookstore lists books, articles, and tapes available on OCD. Some of these resources are specifically for families and friends of OCD sufferers. Be sure to check out the section of the bookstore called "Books: Family" and "Books: Family-Parenting." If you do not have internet access, you can call the OCF staff and they will assist you. The OC Foundation number is: (203) 315-2190.

Another resource is people who have been in a similar situation. On the internet, there are several chat rooms and bulletin boards related to OCD. Although mostly for OCD sufferers, many family members and friends seek information and assistance there as well. Also, check

to see if there is an OCD support group that meets in your area. Many of them allow people other than OCD sufferers to attend and some even have special groups for families and friends. In addition, the OC Foundation's annual meeting has many programs specifically for families.

Professional help is another option. There are services on the internet where consumers can have their questions about OCD answered by professionals. The most comprehensive service of this kind is the OC Foundation's "Ask the Experts" feature which can be accessed through the Foundation's website. Members of the OCF Scientific Advisory Board answer the questions that are posted on the web site. "Ask the Experts" can be utilized not only by OCD sufferers but also by family members and friends as well.

Despite the value of resources we have already mentioned, many people need ongoing professional consultation to deal successfully with a friend or family member who is an RA. A therapist can help you anticipate and deal with real life complications that arise as you implement the steps we have outlined. Admittedly, you may have to search to find the expertise you need. There is still a limited number of clinicians experienced with OCD and not all of them work with families. We suggest you begin by contacting OCD therapists in your area and ask them if they have ever provided this type of service. If you cannot find an appropriate therapist in your area, technology offers another option. Some of the major treatment centers provide ongoing phone or email consultation to families and friends of RAs. For over 15 years, our clinic has been helping families from various parts of the country through long distance consultation.

The good news is there is hope for families and friends confronted with the difficult challenge of dealing with an RA. They have options other than minimizing or accommodating the OCD or waiting helplessly for the recovery avoidance to go away. They can begin by doing something for themselves and focusing their efforts on the things they can actually control. No matter what you do, there is no guarantee the OCD sufferer will ever decide to seek help. However, recovery avoidance is less likely to persist when those around the RA are actively seeking to improve their own quality of life.

From the President

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University and director, Anxiety Treatment and Research Centre, St. Joseph's Hospital, Hamilton, Ontario, Canada;

* "The Effectiveness of Cognitive-Behavioral Treatment for Obsessive-Compulsive Disorder: Do Symptom-Based Subgroups Respond Differently," John E. Calamari, Ph.D., associate professor and director, Anxiety and Obsessive-Compulsive Disorders Treatment and Research Program, Finch University of Health Science, Chicago, IL;

* "Cytochrome p450 2D6 Polymorphisms/Duplications and Serotonin Uptake Inhibitor Response in OCD: A Pilot Study," Stefanie Schwartz, Ph.D., postdoctoral fellow, and John Black, M.D., professor of Psychiatry and director of the Psychogenomics Laboratory, Mayo Clinic, Rochester, MN;

* "Compulsive Hoarding among Elderly People," Gail Steketee, Ph.D., professor, Boston University School of Social Work, Boston, MA; and

* "The Effects of Cognitive Behavioral Treatment on Neurochemical Compounds in Patients with OCD: Evaluation of Proton Magnetic Resonance Spectroscopy," Stephen Whiteside, Ph.D., postdoctoral fellow, Mayo Clinic, Rochester, MN.

We are very grateful to the Review Committee, headed by Dr. Lorrin Koran, professor of Psychiatry at Stanford University Medical Center and director of the Stanford OCD Clinic. The Committee reviewed all the grant proposals and submitted recommendations to the board of directors. Committee members, all of whom are on the OCF Scientific Advisory Board, included: Steven Friedman, Ph.D., professor of Clinical Psychiatry and director of the Anxiety Disorders Clinic of the State University of New York Health Science Center in Brooklyn, NY; William Hewlett, M.D., Ph.D., director of the OCD/Tourette Program at Vanderbilt University Medical Center in Nashville, TN; Suck Won Kim, M.D., associate professor of Psychiatry, University of Minnesota Medical School, Minneapolis, MN; and Christina Taylor, Ph.D., associate professor of Psychology, Sacred Heart University, Fairfield, CT.

All of them gave generously of their own time to read and review each proposal, draft comments and repeatedly teleconferencing to share individual evaluations. A two-step process was utilized this year. First, each proposal was reviewed and evaluated. The field of

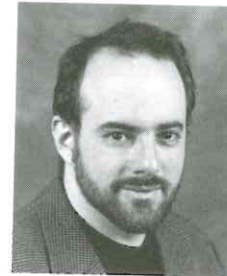
proposals was narrowed down to 10; these investigators then were asked to submit much more in depth descriptions of the techniques required to successfully complete their projects. The next review by the Committee yielded recommendations for funding to the OCF board of directors. The final award winners were then selected. The hard work and dedication of the Review Committee are much appreciated.

The Foundation will be granting \$150,000 for the 2002 Research Awards. This increase of more than \$75,000 over last year's awards was made possible by your continuing support of the OCF Research Fund.

We believe that each one of these projects will lead us to a better understanding of this disorder, which has had such an impact on all of our lives. The following are the expressed goals of the studies:

* Dr. Abramowitz, principal investigator of "Cognitive-Behavioral Therapy for Comorbid OCD and Major Depression," states: "The aim is to develop effective cognitive-behavioral treatments for the 30% of patients with OCD who also have depression." In his study, he will attempt to develop and evaluate the effectiveness of a cognitive behavioral intervention that combines exposure and response prevention therapy with procedures that are often helpful in reducing the symptoms of depression. It's Dr. Abramowitz' hypothesis that by focusing on comorbid major depressive symptoms early in the treatment for OCD, there will be a substantial reduction in obsessions and compulsions. He is predicting that combining treatment modalities from the beginning is going to be a more effective way of treating both conditions.

* "The hypothesis behind 'Home-Based versus Hospital-Based Behavioral Treatment of Obsessive Compulsive Disorder,'" according to its principal investigator, Dr. Antony, "is that individuals who received home-based Exposure & Response Prevention therapy will experience greater improvements in their OCD symptoms, lower rates of relapse in the months following treatment and be less likely to drop out of treatment than patients who are



Dr. Martin Antony

treated at the treatment provider's office." It was decided to fund this study because its results should have a direct impact on treatment. It is the type of study that has the potential to help people with OCD immediately

and directly.

* "With our study, 'The Effectiveness of Cognitive-Behavioral Treatment for Obsessive-Compulsive Disorder: Do Symptom-Based Subgroups Respond Differently?'" commented Dr. Calamari, "we plan to test whether there are significant differences between OCD symptom subgroups and, if so, whether there are significant differences in OCD subgroups' responses to specific treatment. In recommending this project to the board of directors, Dr. Koran emphasized the fact that this project has great potential for finding more effective treatment for OCD, which is one of the Foundation's main goals.

* "What we are trying to do with this research in our study, 'Cytochrome p450 2D6 Polymorphisms/Duplications and Serotonin Uptake Inhibitor Response in OCD: A Pilot Study,'" explained Dr. Schwartz, one of two principal investigators on the project, "is to determine if there is a genetic abnormality that causes rapid metabolism of serotonin reuptake inhibitors and if so, is it the reason that these medications are



Dr. John E. Calamari



Dr. Jonathan Abramowitz



Dr. Stephanie Schwartz



Dr. John Black

ineffective for some people who take them." The board was especially enthusiastic about this project because at this time the available medications demonstrate benefit to only 60% of the people who take them; and even among those responding, the drugs are only partially effective.

From the President

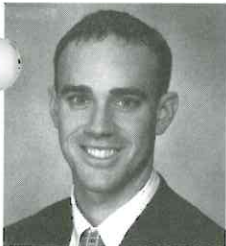
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Dr. Gail Steketee's project, "Compulsive Hoarding among Elderly People" was chosen because it is a huge personal, familial and social problem and because there is so little known about its causes and its treatment. According to Dr. Steketee, "hoarding is very difficult to treat and cure. What we are proposing to do in our study is to look at the emotional, cognitive and behavioral features of hoarding among elderly individuals so that we can design effective interventions."



Dr. Gail Steketee

* The board voted to fund Dr. Whiteside's study, "The Effects of Cognitive Behavioral Treatment on Neurochemical Compounds in Patients with OCD: Evaluation of Proton Magnetic Resonance Spectroscopy" because it has the potential to lead to an understanding of the possible differential neurological treatment effects of medication and CBT and to increase the understanding of the brain-behavior relationship within OCD. In doing this study of the brain's circuitry,



Dr. Stephen Whiteside

Dr. Whiteside and his group hope to learn how cognitive behavior therapy impacts brain function and how the observed differences in brain function between people with and without OCD are associated with the severity of one's symptoms. We felt when evaluating this study that it had the potential to unlock some of the key questions about what "causes" OCD. These are questions that have to be answered before we can hope for a universal cure.

Everyone on the board is very excited about these projects. They have the potential to take us closer to our goal of "Effective Treatment for Everyone with OCD." I wanted to share these choices with you and to also, on behalf of the board and everyone who suffers with OCD, thank those of you who made this research possible through your contributions to the OCF Research Fund. You are truly responsible for taking us all one step closer to a cure.

Best regards,
Janet Emmerman
President
Board of Directors

BULLETIN BOARD

(continued from page 2)

Cognitive Therapy for Obsessive-Compulsive Disorder

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

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

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

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

University of California, Los Angeles Obsessive Compulsive Disorder Research Program: PET Scan Study

This is a 12-week study that is researching the effects of the medication Paxil (Paroxetine) on brain glucose metabolism in people with Obsessive Compulsive Disorder.

All study participants receive 12 weeks of treatment with Paxil, a medication that has been shown to be effective for OCD. Participants who do not show significant improvement in OCD symptoms at the end of 12 weeks, will be offered a second medication – Risperidone to augment the effects of the Paxil. Risperidone will take approximately another 4 weeks to show effect. A PET (Positron Emission Tomography) scan of the brain is done prior to commencing the medication regimen, and at the end of 12 weeks. A third scan may be done for those participants who go on to take Risperidone. Participants will also receive an MRI (Magnetic Resonance Image) scan of the brain.

The purpose of this research is to observe changes in brain metabolism before and after treatment in an attempt to help us to identify the specific brain regions responsible for OCD.

For more information on this study, please feel free to call Karron Maiment, RN, M.A. (310) 794-7305.

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

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

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

Please contact:

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

Study of St. John's Wort for the Treatment of Obsessive Compulsive Disorder

The Clinical Trials Department at Rogers Memorial Hospital-Milwaukee under the direction of John Greist, MD and James Jefferson, MD and the Dean Foundation, under the medical direction of Leslie Taylor, MD are seeking volunteers to participate in a 12-week outpatient study of St. John's Wort for the treatment of Obsessive Compulsive Disorder (OCD). You may qualify to participate if:

- * You are between the ages of 18 and 65
- * You have experienced symptoms of OCD for at least the last year
- * Your general health is good
- * You have written and oral fluency in English

Eligible participants will receive a comprehensive psychiatric diagnosis, frequent assessments by a physician and research medication at no cost. Participants will be reimbursed for travel.

For additional information please call:

Beverly Duty, study coordinator or Gemma Warner, study coordinator
Rogers Memorial Hospital-Milwaukee
11101 West Lincoln Avenue
West Allis, WI 53227
(toll free) 1-877-676-6600
Dean Foundation
2711 Allen Boulevard
Middleton, WI 53562
(toll free) 1-800-844-6015 ext. 2338

OCD and Depression

The Mayo Clinic OCD/Anxiety Disorders Program is seeking adults with OCD who are also depressed to participate in a treatment study. The purpose of this research is to examine the

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Using the ADA

Sharon Lewis, J.D.

Patricia Perkins, J.D.

One of the highest hurdles to getting back into the job market for people who have had a disabling bout of Obsessive Compulsive Disorder is how to explain that gaping hole in your resume at the job interview. What do you say when the interviewer asks you: What were you doing from 1999 until 2002? How come you graduated from college in 1984 but started in 1972? Why didn't you work for five years after you finished grad school? There is help. The Americans with Disabilities Act.

What we thought we would do for you in this edition's ADA column was recreate an interview situation and use it to illustrate what information the ADA allows potential employers to ask about and what kinds of inquiries are completely off limits. **Here's where we reiterate what we said in our first article: This column and the musings in it are not meant to be legal advice. If you have questions or concerns about a specific situation, you need to discuss any actions or steps you are considering taking with your own attorney before you act.**

As you know from our previous column, the ADA prohibits an employer from discriminating against persons who currently have a disability; persons who have a history of a disability; persons who are regarded by others as having a disability whether or not they actually have one (a person receiving therapy or medication to control some condition that is not disabling); and persons who are not disabled but who are discriminated against because of their relationship or association with a person who has a disability (i.e., a parent with a disabled child).

In the hiring context, the ADA requires an employer to evaluate the applicant's ability to do the job without regard to that person's disability

In the hiring context, the ADA requires an employer to evaluate the applicant's ability to do the job without regard to that person's disability or to that person's possible need for an accommodation. To that end, the ADA provides that an employer may not ask an applicant any questions related to his or her medical or mental health condition until after a conditional job offer has been made.

As usual, there is a little more to the story. In situations where the job applicant has a visible disability, an employer may question the

applicant on how he or she can perform essential functions of the job. For example, an employer may ask a visibly hearing impaired applicant for a job requiring phone contact with customers to describe how he would perform this function or to ask a wheelchair-bound applicant for a job requiring overnight travel whether she could travel

The ADA was enacted to require employers to give competent people with disabilities a "right" to work equal to every other similarly qualified applicant

alone and remain overnight.

For individuals with disabilities that are not visible, such as, psychiatric disabilities, however, the ADA requires an employer to stick to questions related to the applicant's current ability to do the job – whether the applicant has training, experience, and talent to do the job. By prohibiting any questions related to an applicant's medical or mental health condition until after a job offer has been made, the ADA prevents gratuitous inquiry into areas not relevant to the applicant's ability to perform the job. This makes the interviewing process a little easier to navigate.

This legislative stifling of curiosity seeks to balance the competing public interests in the situation. It is in the best interest of society in general and the individual with a disability specifically to be able to do a job that he or she has the ability, talent and interest in rather than to subsist on welfare or disability benefits. It is in the interest of the employer to have employees who can be relied upon to do the job they have been hired to do well, consistently and in a timely manner. Sometimes these basic interests seem incompatible. As a society, however, we are just beginning to realize that a person with a disability can be just the worker an employer needs. The ADA was enacted to require employers to give competent people with disabilities a "right" to work equal to every other similarly qualified applicant.

The ideal behind the ADA was to level the playing field. To give people with disabilities an equal chance to be evaluated on their ability to do the job and to take the disability and/or need for an accommodation out of the equation. Obviously, the ADA can't put blinders on employers. There are disabilities and situations that an interviewer can see or read or extrapolate from the candidate's appearance, resume or background. The

ADA, however, limits the discussion to the elemental issue in every job interview – can the candidate do the job. It does this by prescribing what an interviewer can and cannot ask an applicant about his or her medical or mental condition. The mandates of the ADA were developed so that the essential information – whether or not the candidate has the training, experience and talent to do a particular job – can be evaluated without any reference to the disability.

To illustrate how this plays out in reality, we decided to set up an interview scenario and add a running commentary that points out which questions can be asked and what questions have to be answered and how these questions can be answered to protect your rights under the ADA.

The Players

The players are a young man in his early thirties applying for a software engineer position at a software manufacturer that employs more than 1,500 people and the company's human resource person. Our applicant's resume shows that he got his bachelor's degree cum laude in Computer Science from a prestigious engineering school in 1995 and then, in 1999 he enrolled in that university's MBA program and completed it two and one-half years later in December 2001. In the experience section of his resume, there are a number of summer jobs during college and a one-year stint at an entry-level position just after getting his BS and no other employment

ADA, however, limits the discussion to the elemental issue in every job interview – can the candidate do the job?

after 1996. The reason why our applicant left his job after the first year was because he could no longer get out of the house because of his rituals. He found out six months after leaving his job that he had OCD and that was why he was performing endless hours of cleaning and checking rituals every day. For two years after being diagnosed with OCD, he was treated ineffectively. Finally, in desperation he went to a residential program where he finally found the effective treatment. He then entered the MBA program that took him two and one-half years to complete.

The Interview

HR person: I had a chance to review your resume before you came in this morning. I have to say that we have several employees

When You Have OCD

who were in the same program you were at Engineering State and we have been very impressed with their background and training. We have also learned over the years that our business is such that a software engineer with an MBA fills a very distinct need. HOWEVER, I was mystified by the fact that you were only employed for one year after you got your BA and have had no employment

The ADA doesn't prohibit questions that might reveal a disability if that revelation is the indirect result of responding to a proper question.

since. What were you doing?

Commentary

Under the ADA is this a legitimate question? Does he have to answer it? The legality of the question aside, what are the practical considerations for answering/not answering? What is an acceptable way to utilize the protections of the ADA in responding to this question?

From a legal and practical standpoint, the simple answer is yes. This is a legitimate question under the ADA and the applicant would not be protected by the ADA if he chose not to answer.

As to the employer's right to ask the question, the ADA only prohibits an employer from asking questions relating to an applicant's medical or mental health condition prior to making a job offer. This means the interviewer cannot directly ask an applicant if he or she has a specific disability. This also includes, according to the commentators who write about the reach of the ADA, questions that are *closely related* to disability. This is the kind of murky statement that makes it difficult to know whether our interviewee has to answer the question we had the human resource person ask him above. However, the ADA doesn't prohibit questions that might reveal a disability if that revelation is the indirect result of responding to a *proper* question, such as, any of the following. A prospective employer may ask questions related to an applicant's ability to perform specific job functions; questions about an applicant's educational background, work history and the required certificates and licenses. An interviewer can also ask an applicant to describe or demonstrate how he would perform tasks that are specific to the job being sought.

In our scenario, what does this mean? Is the

interviewer precluded from asking our job hunter what he did from when he left his job in 1996 until he began graduate school in 1999 because the answer might reveal an undetectable *disability* or can she ask about it because it relates to his work history?

In our scenario, the interviewer appears to have a legitimate job-related reason to ask about the gap in our applicant's employment from 1996 until he entered the MBA program. Since he is applying for a computer engineer position, the employer would certainly want to be sure that his computer science skills were up-to-date and had not gone stale during the five-year hiatus. She would also want to know what explains the shift from computer science to business. Did our applicant find during his one year of employment that he had no interest or was not suited for computer science? Was he fired?

Whether the ADA would come into play at all depends on what the follow-up questions are. The interviewer needs to stick to job-related concerns, such as, those stated above. If our interviewer can articulate a legitimate job-related reason for asking the questions and can show that she asks this question of all applicants in similar situations, the question is allowable under the ADA. If, on the other hand, the interviewer asks questions that seek or appear designed to elicit more personal information that ultimately disclosed our applicant's disability, there may be a basis for showing that the interviewer asked illegal questions and discriminated against our applicant because of his actual or perceived disability.

Whether the ADA would come into play at all depends on what the follow-up questions are.

As to our applicant, the reason why he has to answer the question is practical rather than legal. There is no law requiring an applicant to answer this question. The ADA, however, does not prohibit an employer from disqualifying an applicant who refuses to answer it. Some courts have ruled that if an employer asks an illegal question, the employer cannot disqualify an applicant who refuses to answer or who provides an untruthful answer. A prudent employer, then, makes sure that its questions are legal and job-related and will not ask overtly illegal questions. In the ADA context, that means no pre-offer medical or mental health inquiries. A prudent applicant will not take the high risk of being disqualified by refusing to answer the question.

In our scenario, it would be very high risk for our applicant to take the position that the question about the gap in his employment is illegal and refuse to answer. This would be so even if he tries to finesse with a response along the lines of politicians responding to TV commentators, i.e., "The important thing about that is..." and then goes on to explain how he is currently qualified to do the job. Our applicant should expect to be questioned about the gap in employment and be prepared to address the employer's legitimate concerns. Why did you leave the first job? Have you kept your computer science skills up-to-date? Why did you switch to an MBA?

While the ADA prohibits pre-offer medical and mental health inquiries so as to take disability out of the hiring equation, it does not require an employer who is made aware of an applicant's disability to hire that individual.

Regardless of whether our applicant refuses to answer or deflects the question and segues into more job-related information, it will raise a red flag and likely cause the employer to fill in the gaps and speculate on why he was unemployed for so long.

Unless the interviewer asks follow-up questions that appear to elicit more personal information and that suggest a concern with medical or mental health, it will be difficult to show that she speculated that disability was the reason and not some other reason (like a series of failed jobs that the candidate is not disclosing) or even to show that speculation played any part in the decision to turn the candidate down. The interviewer would appear to have a legitimate, nondiscriminatory reason to turn our applicant down because he had less recent relevant computer science experience than the successful applicant and the ADA would likely not afford our applicant any protection.

A second option is for our applicant to explain the employment gap without disclosing his disability. He could say, for example, that he left the first job to take care of some personal and family obligations and then go on to explain why he chose to get an MBA before returning to the job market and how he is currently qualified with up-to-date computer science skills. This type of response refocuses the inquiry on job-related concerns but gives enough explanation for the gap to

Research Digest

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

OCD seldom occurs by itself. Most sufferers also experience symptoms and signs of one or more additional psychiatric disorders. Depression is very common, occurring in up to two-thirds of OCD patients at sometime in their lives. The articles reviewed here describe other disorders that can occur with OCD (comorbidity = sicknesses together). A careful diagnosis will identify most comorbid conditions. Comorbid disorders complicate treatment of OCD, but once recognized they can be managed properly so that the OCD can be treated as effectively as possible.

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

Attention-deficit/hyperactivity disorder in children and adolescents with obsessive-compulsive disorder: fact or artifact?

Journal of the American Academy of Child and Adolescent Psychiatry, 41:52-58, 2002, D.A. Geller, J. Biederman, S.V. Faraone et al.

As many as 30% of children and adolescents with OCD are also diagnosed with attention-deficit/hyperactivity disorder (ADHD). These researchers look at whether the ADHD-symptoms (i.e., poor attention span, distractibility, impulsive behavior) represent true ADHD or represent ADHD-like symptoms stemming from the OCD. For example, is the poor attention span in children with OCD caused by the child's focus on intrusive obsessions or does it indicate a true ADHD? The findings suggest that ADHD-like symptoms in children with OCD represent a true ADHD and that the ADHD is independent of the OCD diagnosis. In addition, the average age at onset of ADHD preceded by several years the development of OCD, which would indicate the ADHD-like symptoms are not secondary to OCD symptoms. Because ADHD and OCD are treated by different medications, children with both disorders will likely need both drug therapies.

Comorbidity of obsessive-compulsive disorders and duration of eating disorders

International Journal of Eating Disorders, 31:284-289, 2002, G. Milos, A. Spindler, G. Ruggiero et al.

Eating disorders and OCD often co-exist and are similar in some aspects. Additionally, the serotonin system is involved in both disorders and similar medications have been found effective for both disorders. This study of 237 females with eating disorders (84 with anorexia nervosa and 153 with bulimia) reported OCD in 29.5% of these women. Researchers found that subjects with OCD developed the eating disorder at a much younger age than those without OCD. Also, subjects suffering from OCD reported a significantly longer duration of their eating disorder than those without OCD. Thus, results showed both a high comorbidity between OCD and eating disorders and suggest that OCD may play a role in the course of eating disorders. These findings further support a link between OCD and eating disorders.

Symptom stability in adult obsessive-compulsive disorder: data from a naturalistic two-year follow-up study

American Journal of Psychiatry, 159:263-268, 2002, D. Mataix-Cols, S.L. Rauch, L. Baer et al.

Following 117 adults with OCD over two years, this study looked at changes or stability of specific OCD symptoms. Patients were administered the Yale-Brown Obsessive Compulsive Symptom Checklist (YBOCS Checklist) four times over the two years. For the most part, patients maintained their symptoms during the two years, although some symptoms were more stable than others. Also, if symptoms did change, the changes tended to occur within rather than between symptom dimensions. For example, a patient with contamination obsessions with "cancer germs" changed to contamination obsessions with AIDS germs. This maintenance of symptoms for adults is in contrast to the reports of dramatic symptom changes across time in children and adolescents with OCD. For both children and adults

the severity of OCD tends to "wax and wane," but for adults the content of the obsessions tends to be retained over time.

Treatment of scrupulous obsessions and compulsions using exposure and response prevention: a case report

Cognitive and Behavioral Practice, 8:79-85, 2001, J.S. Abramowitz

Scrupulosity is obsessional doubt whether one has committed a moral or religious sin. Scrupulous doubts and rituals go beyond the requirements of religious law and often are focused on less important aspects of the particular religion. This case report describes the successful use of behavior therapy for a 36-year-old Catholic man with scrupulosity. He spent hours each day reviewing his conversations and activities to be sure he hadn't sinned and he compulsively sought reassurance that he had acted "correctly." Dr. Abramowitz discusses specific exposure and ritual prevention strategies used and issues particular to working with religious patients. The therapist needs to be sensitive to religious values involved and help the individual distinguish between healthy and unhealthy religiosity. The treatment goal is to help patients practice their religions as intended, not as a part of OCD, an illness.

Obsessive-compulsive hoarding: symptom severity and response to multimodal treatment

Journal of Clinical Psychiatry, 63:21-27, 2002, S. Saxena, K.M. Maidment, T. Vapnik et al.

Compulsive hoarding and saving symptoms, defined as the acquisition of and inability to discard worthless items, are found in many patients with OCD. Twenty of 190 patients with OCD (11%) being treated at the University of California at Los Angeles OCD Partial Hospitalization Program were identified as having a compulsive hoarding syndrome. This study compared these 20 patients with compulsive hoarding to the patients with non-hoarding OCD. In particular the severity of symptoms and the response to combined treatment with medications and

Research Digest

intensive cognitive-behavioral therapy (CBT) were compared. Both groups had similar pretreatment Yale-Brown Obsessive Compulsive Scale (YBOCS) scores and both groups improved at the end of the 6-week program. However, the hoarding OCD patients did not respond as well to treatment and had more severe symptoms and functional impairment than nonhoarding OCD patients at the end of treatment.

Religiosity and religious obsessions in obsessive-compulsive disorder

Psychiatry Research, 104:99-108, 2001, C. Tek and B. Ulug

The prevalence of OCD has been found to be similar across countries. However, between countries the frequency of specific symptoms, particularly religious obsessions, has varied. Religious obsessions are common OCD symptoms in countries with large Muslim and Jewish populations. In this study the relationship between religiosity and religious obsessions is investigated through an evaluation of 45 Turkish patients with OCD. Turkey has a predominantly Muslim population and here 42% of the patients were found to have religious obsessions. There was no significant difference in the overall severity of obsessions and compulsions between patients with and without religious obsessions. There was a tendency that patients with a variety of obsessions were more likely to also have religious obsessions. Researchers conclude that religion appears to be one more arena where OCD expresses itself, rather than being a cause of the disorder. They suggest clinicians should be sensitive to the fact that religious obsessions may be more common in certain cultures and the religious obsessions should be treated as obsessions rather than religious phenomena.

Cyclothymic OCD: clinical picture of a neglected and under-recognized entity (In French)

La Presse Medicale, 31:644-648, 2002, E.G. Hantouche, C. Demonfaucon, J. Angst et al.

A high rate of cyclothymia, a milder form of bipolar disorder, was reported in this survey of patients participating in the French Association of Patients Suffering from OCD: 30% reported hypomania and

50% cyclothymia. A comparison is made between 302 OCD patients with comorbid cyclothymia and 272 OCD patients without cyclothymia. Patients with both disorders were more likely to suffer with aggressive, impulsive, religious and sexual obsessions, have an episodic course, have a higher rate of major depressive episodes associated with a higher rate of suicide attempts and psychiatric hospitalizations, and have a less favorable response to OCD treatments. Researchers suggest that cyclothymic OCD could be a distinct subtype of OCD and one under-recognized in clinical practice.

Comorbid posttraumatic stress disorder: impact on treatment outcome for obsessive-compulsive disorder

American Journal of Psychiatry, 159:852-854, 2002, B.S. Gershuny, L. Baer, M.A. Jenike et al.

This study compared behavioral treatment of patients with OCD versus patients with OCD and posttraumatic stress disorder (PTSD). Subjects were 15 patients with treatment-resistant OCD, 8 suffering with both PTSD and OCD. Although all patients had a diagnosis of treatment-resistant OCD at admission, those patients without comorbid PTSD had significant improvements in OCD and depression after intensive behavior therapy. In contrast, patients with comorbid PTSD did not have significant improvements in OCD and depression. When an initial decrease in OCD symptoms occurred, it was followed by a worsening of PTSD (increase in trauma-related thoughts, flashbacks and nightmares) and the OCD symptoms then increased. Researchers conclude that behavioral treatment of OCD may be hindered by comorbid PTSD. They suggest that treatment for OCD should be combined with systematic treatment for PTSD when the disorders coexist. (This study was funded by an OCF Research Award.)

Abstractor's Comment:

For further information on posttraumatic stress disorder, visit the Madison Institute of Medicine's website at: www.ptsd.factsforhealth.org. This website can help you understand PTSD, determine if you may be suffering from it (there is an online screening test you can take) and lead you to additional resources.

ADA & OCD

(continued from page 9)

minimize speculation that you have something relevant (such as, a poor, undisclosed job history) to hide. Again, this type of response will not bring the ADA into play unless the interviewer asks the type of improper questions described in the first response scenario.

A third option that will bring the ADA into play and afford some protection if our applicant is turned down for the job is to disclose his disability. If he makes that choice, he should explain simply and without going into detail that he was diagnosed and treated for OCD which is now under control and has been since 1999.

The ADA prohibits any further questions about his condition, symptoms, course of treatment, prognosis, or need for any accommodations. With the simple disclosure of the disability and, particularly if the interviewer asks any of these improper follow-up questions, our applicant would have a basis to challenge being turned down for the job under the ADA and to claim that he was denied the job because of his disability. Our applicant would still face the burden of showing that his disability (actual, perception or record of) was the reason and not that the interviewer simply selected another equally qualified applicant with more recent, relevant experience. While the ADA prohibits pre-offer medical and mental health inquiries so as to take disability out of the hiring equation, it does not require an employer who is made aware of an applicant's disability to hire that individual and the employer can choose to hire any of the qualified applicants.

Where does this leave our applicant? The ADA affords basic protection in that he is protected from direct inquiries regarding his medical and mental health, and questions that may be asked gratuitously or as follow-up to any disclosure of his disability he may choose to make. This should make the interview a little less difficult or uncomfortable in that he should not have to reveal any details he does not make voluntarily (as we said above, if he chooses to disclose his disability as the reason for the employment gap, he should do so simply, matter-of-factly and without detail and turn the focus on his current ability to do the job). The ADA, however, does not prevent the inquiry into the employment gap – the source of our applicant's anxiety – so he should anticipate the question and have a response prepared. Whether he chooses a more generic "personal and family obligations" explanation or disclosure of the disability, he must be prepared to give a direct answer and then shift the focus onto his present skills and abilities and how he can do the job.

(continued from page 3)

NEWSLETTER: How is a patient's treatment program developed? Who is involved in designing it?

JENIKE AND OSGOOD-HYNES: Upon admission, each person is assigned a psychiatrist, a psychologist and a social worker.



Leslie Shapiro, LCSW,
Behavior Therapist

Within the first few days, each member of the team meets with the patient individually to discuss the individual's symptoms. Behavior therapists typically meet with the patient two to

three times a week to review treatment progress, create and revise behavioral plans as needed, and assist the patient in doing exposure and response prevention tasks. Psychiatrists typically meet with each patient once a week to assess and revise medication as needed. Social workers might meet with a patient from one to three times a week. Included in the team are the many skilled counselors, who assist every patient with challenging his/her OCD symptoms throughout the day and evening. On-going communication between team members, as well as clinical rounds twice a week, keeps the treatment focused and continually addressing the patient's specific needs.

NEWSLETTER: What part do medications play in your treatment protocols? Does every participant in your program have to be on medication? Who determines what medications a patient will try and how or if they will be augmented and changed?

JENIKE: The majority of our patients have failed many medication trials. Nonetheless, we review their medication history and current drugs, and try new agents or adjust medications as clinically indicated. Most patients are on medication while at the OCD Institute. For more information on medication, readers can go to: www.mgh.harvard.edu/psychneuro/overall.htm or the OC Foundation web site: www.ocfoundation.org

NEWSLETTER: Can a patient participate in your residential program if s/he does not want to take medication?

JENIKE: Yes, occasionally we see patients who do not want medication. We are willing to see if they can follow the CBT program without drugs. However, if it is clear that they cannot do the program this way, we request that they try medication or we have them go back to outpatient treatment.

NEWSLETTER: Cognitive behavior therapies, especially, Exposure and Response Prevention, are integral treatments at the OCDI. Do you really have patients doing E&RP 24/7?

JENIKE AND OSGOOD-HYNES: We have skilled counselors who are at the OCD Institute 24 hours per day. We have a two hour Exposure and Response Prevention group in the morning each day in which a staff member is available to assist patients in performing behavioral tasks with the focus on resisting rituals. We also have an Exposure and Response Prevention group in the afternoon in which the patients are asked to resist their rituals on their own. We have found that patients who do not do exposures and response prevention by themselves, without a coach, before they go home, have a very high relapse rate.

The self-directed exposures are crucially important to get the lasting improvements that patients want. If patients do well at the OCD Institute, but relapse when home, we have not done our job. In addition, patients are asked to generate a weekly contract in which they set goals to work on additional E&RP tasks above and beyond the work they are doing in the daily E&RP groups. While it is unrealistic to expect that people with moderate to severe OCD can challenge each and every OCD urge that comes up 24/7, we do ask that people do a lot of hard work while here.

NEWSLETTER: What is the theory behind total immersion in E&RP work at the OCDI?

JENIKE AND OSGOOD-HYNES: While OCD is clearly a biologically-based disorder, learning principles also influence OCD symptoms. The experience of anxiety is aversive and uncomfortable; and when anxiety is triggered by an obsession, most people will do anything, such as, performing physical or mental rituals, to try to make it go away. When you feel better by getting rid of an aversive anxiety experience (even if it's temporary), this is called negative reinforcement. The next time you encounter this OCD-triggering situation, you feel the only way to get the anxiety to go down is by doing the ritual you have done before. This causes the rituals to be strengthened and increase in frequency, intensity and duration.

The learning principle behind Exposure and Response Prevention is called habituation. If you allow yourself to sit with the experience of anxiety and not give in to your rituals or avoidance behavior, you are in effect teaching your mind and your body that the anxiety can go down on its own without having to give in to what

the OCD is telling you to do. Through this conditioning process, you are reteaching yourself that a previously OCD triggering situation does not have to result in an anxiety response which over time leads to less of an urge to perform the compulsions or avoidance behavior. Through habituation a person can reduce their OCD symptoms.

But the key to all this is repeated practice at facing your fears. This means doing the exposure and response prevention tasks frequently. This is an important principle. The more "behavior therapy moments" you can participate in on a daily basis, and again day after day, the more likely you are to experience habituation and see a reduction in your OCD symptoms. This is why we have people who come to the OCD Institute doing so many exposure and response prevention tasks.



Desnise Egan, MA, clinical coordinator
Tim Thomas, head counselor

NEWSLETTER: How do patients adjust to total immersion in behavior therapy? Do you start gradually with new patients, building up day by day? How do patients acclimate themselves?

JENIKE AND OSGOOD-HYNES: We take each patient where s/he is. Most need a gradual exposure to the things they fear. Some can jump right in as long as they are in a supportive environment. One of our skilled behavior therapists is assigned to each patient and tailors the plan to the person. There are two approaches to doing exposure and response prevention: gradual and flooding. Both approaches require setting up a fear hierarchy, that is, a list of the various situations that trigger a person's OCD symptoms and listing the level of anxiety associated with not doing it the OCD way. Most people prefer the gradual approach although some prefer to do flooding. The behavior therapist will work with the resident to individualize the treatment approach that will work best for them. Doing exposure and response prevention can be a lot of hard work so we try to work with the resident to discuss the pace of the therapy process. Many different factors are considered when reviewing how fast or slow one should progress up a fear hierarchy.

NEWSLETTER: The OCDI has the reputation of treating the worst cases of OCD. It's the program to get into when nothing else has worked. How do you get people who are totally consumed with OCD rituals and compulsions to begin doing E&RP? Do you do it gradually? Do you start it after the medication seems to be working?



OCDI Counselors
Jordana, Alyssa and Matt

JENIKE AND OSGOOD-HYNES: As with all tasks, when there are a lot of items on your list of things to accomplish, it's one step at a time. Medication and behavioral treatment occur simultaneously. Behaviorally, we usually start with either the symptom which causes the most dysfunction or interference in a person's life, or possibly start with the area a person feels most motivated to work on reducing. For people that have numerous areas where the OCD impacts their life, we might choose a few areas to start doing the exposure and ritual prevention and put the other areas temporarily on hold before working on them. However, relatively quickly, we will start incorporating more and more areas of OCD symptoms to tackle. Medication management works closely with how people are doing in their behavioral work, and behavioral interventions may be altered depending on what is happening with a person's medication.

NEWSLETTER: Is there a set duration for treatment at the Institute? What determines how long someone will stay in the program? Is there a typical period of time people stay at the OCDI?

JENIKE: When we first opened the OCD Institute, we tried to keep at CBT treatments as long as we could. In fact, we had some patients stay with us over a year. Over time, we noted that if patients had not gotten actively into treatment and started to improve within the first month of treatment, that they were not going to be able to utilize our approach no matter how long we kept them. Thus, early gains predicted long-term improvement. We now carefully assess patients early in treatment and discharge them if they are unable or unwilling to follow our treatment plans. Some patients will not comply at a first admission; and we readmit them later when they are more willing to

follow a productive plan. It is clear that the patient is the one who sets the agenda when it comes to determining when they are ready to get better. If a patient is at the OCD Institute for someone else (parents or spouse, for example), he/she often doesn't do well.

NEWSLETTER: Most of the other Intensive Treatment Programs we've done interviews on have a set duration. The OCDI doesn't. When is the program over for a patient? When he or she is "cured"? Competent at managing symptoms? Not making any more improvement?

JENIKE: We generally try to keep patients a maximum of three months. However, patients can apply to me personally to extend their stay if they are still improving and working hard. The last couple of years, it is unusual for a patient to stay past the three-month time.

NEWSLETTER: How successful is your program? How successful are you with individuals who have moderate OCD? Moderately severe OCD? Very severe OCD? Totally disabling OCD?

OSGOOD-HYNES AND JENIKE: We are continually assessing our program and its potential benefit for people with various OCD severity levels and for people with various OCD subtypes. Looking at the data for the past year and a half, across all people who entered the program, 27% said their symptoms were very much improved (reporting an average 61% drop in YBOCS score and a 70% decrease in depression symptoms according to the Beck Depression Index), 42% said they were much improved (reporting an average 35% drop in YBOCS score and a 46% reduction in depression on the BDI), 28% said they were minimally improved (reporting an average 15% drop in YBOCS score and a 14% reduction in depression on the BDI), 3% said they were unchanged (although they report an average 19% drop in YBOCS score and 1% reduction in depression on the BDI) and <1% said they were minimally worse (reporting a 20% increase in YBOCS score and reporting a depression score that doubled).

Across these different groups, there was no significant difference in YBOCS score or Beck Depression score on admission. As part of our research here at the Institute, we continue to look for predictors of success in treatment. Overall over the past year and a half, 76% of the people who entered the OCD Institute reported at least a 25% or more decrease in their YBOCS score from admission to discharge. This is roughly the same improvement level used in drug studies for the patient to be considered a responder to a drug.

NEWSLETTER: You get many patients to go to the Institute who previously had refused all treatment. How do you get them to come to the Institute?

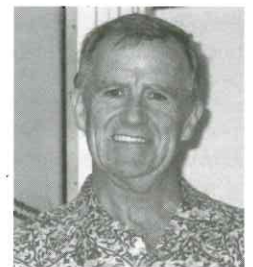
JENIKE: I often deal with some of the patients prior to coming to the OCD Institute. Some respond to information and encouragement that they can get better. Sometimes I tell them about other patients who seemed hopeless who managed to get their lives back.

NEWSLETTER: The Institute is on the grounds of McLean Hospital. McLean is an old and prestigious mental hospital. Patients can be confined at or committed to McLean. Are patients confined or committed to the Institute? Or is it a completely voluntary program?

JENIKE: As noted above, our program is totally voluntary and patients are free to leave at any time.

NEWSLETTER: The Institute is a freestanding "cottage" on the grounds of McLean. What are the accommodations? Dorms, shared rooms, singles? Do patients sleep, eat and treat in the "cottage"? Do they use the facilities at McLean? Can they leave the "cottage" and grounds at will? Do they have free time during the evenings and on weekends that doesn't involve treatment?

OSGOOD-HYNES AND DAVEY: We are a freestanding cottage on the grounds of McLean Hospital, which looks somewhat like a college campus. Most rooms are doubles, but we do have a few singles and a few triples. Residents primarily eat at the OCD Institute, mostly because it's the most convenient given the busy schedule people have with the different daily groups at the program. People are expected to attend the groups throughout the day but during free time people can do as they wish, either relax at the house, travel to local restaurants or stores, or do some sightseeing in nearby Boston. On the weekends, while we do have a few groups, there is more free time scheduled, and we encourage people to get out and participate in some pleasant solo or social activities.



Frank Ryan
Unit Coordinator

NEWSLETTER: What is the size of the staff at the Institute? Are they psychiatrists, psychologists, and therapists? What's the patient/staff ratio?

DAVEY: Each patient is assigned a treatment team, which consists of a behavioral

therapist, a psychiatrist, and a social worker, all of whom meet with the patient individually. In addition, the program also has nurses who assist patients with their medication and other health needs, and counselors who are available 24 hours per day to assist patients in following their individualized plans.

NEWSLETTER: *Is the Institute staffed 24 hours a day? By what level of treatment provider?*

DAVEY: The program is staffed 24 hours per day, 7 days per week. Behavioral counselors, who are college graduates and trained to work with OCD patients, are always available to assist patients.

NEWSLETTER: *What is the typical daily routine of a patient at the Institute?*

OSGOOD-HYNES: Residents have a busy day at the Institute. First group of the day starts at 8:30 AM. However, many people are already challenging their OCD symptoms as soon as they get out of bed either on their own or with the help of one of our counselors. Each weekday has either 7 or 8 groups, although not everyone goes to each group. Group appropriateness is decided in collaboration with your behavior therapist. There are two 2-hour exposure and response prevention groups per day. There are several groups to teach a variety of behavioral skills. We have two cognitive therapy groups, a relaxation group, a motivation group, and symptom specific groups for people struggling with OCD symptoms, such as, scrupulosity, perfectionism, intrusive violent and sexual thoughts or body dysmorphic disorder. We have groups to help people with family issues and with transition; and we also have groups that help people get some exercise and plan some pleasant leisure activities into their life. There are breaks scheduled for lunchtime and dinner. People have some free time in the evenings and more free time on the weekends. During free time patients can watch TV and socialize.

NEWSLETTER: *The OCF has just given a research grant to a team of researchers to evaluate the relative effectiveness of office-based versus in-home E&RP treatment. How can residential treatment be effective for OCD patients if their OCD is connected to their home or other places outside of the hospital?*

OSGOOD-HYNES: That is one of the challenges when a person comes to the Institute. Most of the time, a person's OCD symptoms span a variety of situations. This lends itself to doing the necessary exposure and response prevention tasks here at the Institute. Very frequently we have people going off campus with staff into the community to face various

situations that trigger their OCD. We also have people traveling the various areas of the hospital campus to do their E&RP. If patients live nearby, we have staff go to their home or office to do the E&RP work. For patients who do not live nearby, we ask that they bring items from home or items from work with them into the Institute, or have family members send them specific things that are problematic for them to work on while at the Institute.

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For many people, the E&RP and habituation process can generalize to situations that are similar. However, treatment generalization does not happen for all people. There are some people whose OCD is only triggered in certain specific situations or with certain items which are only at home or at the office. In these situations, home-based or office-based therapy is definitely the better treatment choice.

NEWSLETTER: *Do you have a less intensive program at the Institute?*

JENIKE: We have a few patients in a day program at the OCD Institute. However, it is essentially the same program, but patients don't spend the night. This would not be a good program for patients who have morning rituals that prevent them from getting places on time.

NEWSLETTER: *Are you and the staff at the Institute doing any research projects that involve the program participants? What are they?*

JENIKE: We very rarely do research projects at the OCD Institute because it is mostly a clinical program. At the main Massachusetts General Hospital OCD Clinic, there are many research investigators and they occasionally recruit willing participants from the OCD Institute.

NEWSLETTER: *Is the residential program covered by private insurance, Medicare, Medicaid?*

DAVEY: Many private insurances cover treatment at the OCD Institute. The application asks for insurance information and the program staff will help patients check on coverage from their individual insurers. Medicare does cover the cost of the program at 80%. However, because Medicare does not cover room and board charges, these become the responsibility of the patient. There is a sliding scale for these charges based on a patient's income. Massachusetts Medicaid does cover the program, but not the room and board charges. Other state Medicaid programs do not cover the program at all.

NEWSLETTER: *What other treatment options do you have available for individuals with OCD? A partial program? An in-office weekly program?*

JENIKE: Apart from the day program and full residential program, we have the largest outpatient OCD clinic in the world at Massachusetts General Hospital. We have ongoing evaluations and treatment as well as dozens of research projects aimed at advancing our understanding of OCD in terms of causes, biology and treatment.

NEWSLETTER: *How does a patient get into the Institute? Does he have to be referred by a treatment provider? Can he self-refer? Can a family commit a member to the OCDI?*

DAVEY AND JENIKE: The patient or referring doctor can contact the program director, Diane Davey, directly at davey@ocd.mclean.org or 617-855-3279. Since the OCD Institute is totally voluntary, it cannot accept commitments from family members or others. That really would not make sense, as the patient has to be enthusiastic and motivated to utilize the treatments to get better.

BULLETIN BOARD

(continued from page 7)

effectiveness of a comprehensive CBT program that addresses both depressive and OCD symptoms simultaneously. Participants will undergo a 16-session (twice-weekly sessions for 8 weeks) treatment program and receive follow-up assessments. Participants will be partially reimbursed for their participation.

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

Benefits for participants: You may not receive any direct benefits from participating. However, it is possible that your OCD and depressive symptoms may improve from the CBT you'll receive. There is good evidence that CBT is helpful for both OCD and depression.

Contact information: The study is being conducted by Jon Abramowitz, Ph.D. and colleagues. Further information is available by contacting Dr. Abramowitz at (507) 284-4431, or via e-mail: abramowitz.jonathan@mayo.edu. This study has IRB approval and is being funded by the OC Foundation.

Psychiatrist Wanted

The OCD Clinic at Massachusetts General Hospital/Harvard Medical School invites applications for a Staff Psychiatrist position. Applicants must have interest and experience in the treatment of OCD and related disorders. Responsibilities include patient care, running a clinical research trial and supervision of interns or residents. We offer a supportive research environment, a generous benefits package and competitive salary. Applications will be accepted until a suitable candidate is found. Please contact Dr. Michael Jenike at jenike@attbi.com.

Genetics and OCD

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

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

Risks and benefits for this study: There are no direct benefits from participating in this study.

The study includes a blood draw to obtain a sample of blood, which may cause short-term discomfort. You will also be asked to provide a urine sample.

Contact information: The study is being conducted by Stefanie Schwartz, Ph.D., John Black, M.D., and Jon Abramowitz, Ph.D. at Mayo Clinic. Further information is available by contacting Dr. Schwartz at (507) 284-4431, or via e-mail: schwartz.stephanie@mayo.edu. This study has IRB approval and is funded by the OC Foundation.

Investigational Drug Treatment Study for Obsessive Compulsive Disorder

If you are between the ages of 18 and 65, you may qualify for a no-cost research study to evaluate the efficacy of an investigational drug in the treatment of OCD. This study is being conducted at Massachusetts General Hospital in Boston, MA. This study will be 12 weeks in duration and requires blood draws and ECG's at one or two week intervals over the 12-week span. All participants must be free of medications two weeks prior to starting in the study.

For a free confidential telephone screening to determine eligibility, please call Lisa Jenike at (617) 645-3989. Principal investigator: Michael Jenike, M.D.

Research Participants Wanted for a Brain Function Study in People with Obsessive-Compulsive Disorder

Dr. Scott Rauch and colleagues of the Psychiatry Department at the Massachusetts General Hospital are conducting a research study to examine brain function in people who suffer from obsessive-compulsive disorder.

The entire study will take 3-4 hours and will involve a brief interview, filling out questionnaires, and completing cognitive tasks while "pictures" of your brain are taken using functional Magnetic Resonance Imaging (MRI). Only individuals without pacemakers, aneurysm clips, or other metallic objects in the head and upper body are eligible for MRI. Participants will be paid up to \$100 for their time.

Who is eligible: Individuals who are: right-handed, between the ages of 18-45, currently suffering or have previously suffered from obsessive-compulsive disorder, not pregnant.

For more information: If interested, contact Katherine McMullin at (617) 628-4270.

Intravenous Anafranil Study for Treatment Refractory OCD

This study is investigating whether pulse loading of Anafranil, 150mg on day 1 and 200mg on day 2, results in a marked decrease in the severity of OCD symptoms in treatment refractory cases, and whether this decrease exceeds that produced by double-blind oral pulse loading of identical doses. We plan to enroll 38 patients at Stanford University and 38 at the University of Cincinnati and the University of Florida. Patients are randomly assigned to pulse load intravenous Anafranil or oral Anafranil. Five days after finishing the pulse loading of Anafranil all patients start 12 weeks of treatment with open-label

Anafranil. Patients must be at Stanford, Florida or Cincinnati for one week at the beginning of the study and one day at the end of the study. The 12 weeks of open-label oral Anafranil treatment can be completed in the patient's home city with the assistance of the patient's usual treating psychiatrist.

To be eligible, patients must be 18 to 55 years of age, have moderately severe or severe OCD of at least one year's duration, and have failed to benefit substantially from two or more adequate trials (in terms of dose, > 8 weeks in duration) of anti-OCD medications. Patients who have failed to benefit from previous trials of oral Anafranil are eligible for the study. Additional eligibility requirements will be reviewed with each patient during a detailed phone screen.

For more information contact:
Stanford University Medical Center
Department of Psychiatry
401 Quarry Road
Stanford, CA 94305-5721
Lorin M. Koran, M.D., Principal Investigator
Nona Gamel, Coordinator
gamel@stanford.edu
<http://ocd.stanford.edu>
(650) 725-5180

University of Cincinnati
Department of Psychiatry
Floyd R. Sallee, M.D., Ph.D., Co-Principal Investigator
Kirsten Wilkes, Coordinator
(513) 558-4854

University of Gainesville
Department of Psychiatry
Herb Ward, M.D., Co-Principal Investigator
Nikki Ricciuti, Coordinator
(352) 265-0162

Inpatient Medication Study

The Yale Clinical Neuroscience Research Unit in New Haven has received approval for a six-week inpatient medication study. The study is for patients with Obsessive Compulsive Disorder who are currently taking a serotonin-reuptake inhibitor and are still experiencing distressing symptoms. Patients will remain on the SSRI and the medication riluzole will be added. Riluzole is a benzothiazole medication that is FDA approved for use in ALS. Riluzole's mechanism of action in ALS is unknown but thought to be due to its blockade of glutamatergic transmission. Preclinical and neuroimaging studies have implicate glutamatergic hyperactivity in the pathogenesis of OCD.

All treatment on the Clinical Neuroscience Research Unit is free of charge. We do not go through insurance. Patients should plan to remain on the Research Unit for approximately seven weeks for this protocol. An increased length of stay can be negotiated for treatment purposes. Patients sign in voluntarily to a 13-bed unit and are expected to participate in groups and individual treatment. For more information, contact Suzanne Waysbink, RNC, at (203) 974-7523 at the Connecticut Mental Health Center. HIC#15638.

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