

OCF Gives Five Research Awards

Before the Keynote Speech at the 12th Annual Obsessive Compulsive Foundation Conference in San Diego, CA, the President of the OCF's Board of Directors, Joy Kant of Newton, MA, announced the five winners of the 2005 OCF Research Awards. The winning projects were chosen from among 42 proposals submitted in response to the OCF's "Call for Proposals" for 2005. The total amount of funding for the five awards is \$222,351.12, all of which was donated to the Foundation by its members and people interested in finding effective treatment for everyone with obsessive compulsive disorder. The amounts of the awards vary from \$39,011.00 to \$49,000.00.

The winners of the 2005 OCF Research Awards and their studies are: Alexander Bystritsky, MD, Professor of Psychiatry and Biobehavioral Sciences at the Neuropsychiatric Institute, David Gesson Medical School at the University of California at Los Angeles, Los Angeles, CA, "Treatment Response in OCD to Sertraline and Aripiprazole as Compared

to Sertraline and Placebo;" Marco A. Grados, MD, MPH, Assistant Professor, Department of Psychiatry and Behavioral Sciences, Division of Child and Adolescent Psychiatry, Johns Hopkins University School of Medicine, Baltimore, MD, "Cytokine Levels and Genes in Childhood OCD: a Longitudinal Study;" Eric A. Storch, Ph.D., Assistant Professor, Department of Pediatrics and Department of Psychiatry, University of Florida, Gainesville, FL, "D-Cycloserine Augmentation of Exposure and Response Prevention Treatment for Obsessive-Compulsive Disorder;" James A. Knowles, MD, Ph.D., New York State Psychiatric Institute Division, Columbia University, New York, NY, "Genome-wide Association of OCD in an Isolated Population;" and Randi E. McCabe, Ph.D., Anxiety Treatment and Research Centre, St. Joseph's Healthcare and Department of Psychiatry and Behavioral Neurosciences, McMaster University, Hamilton, Ontario, Canada. The following are descriptions of the five winning proposals.

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From the President

Dear Friends,

In May, I had the opportunity to attend the third annual meeting of the OCF Genetics Collaborative that was held in Boston. Dr. David Pauls, who heads the Neurodevelopmental Genetics Unit at Massachusetts General Hospital, chaired the meeting. Listening to the investigators from seven countries and twenty different universities from around the world made me realize how lucky I was to be a part of this event and to be able to learn more about the advances that are being made by the leading researchers in Obsessive Compulsive Disorder.



Even though I was exhilarated about the information that I was hearing from the investigators, I was also struck by their plea for subjects and for money. During the meeting, I repeatedly heard that they needed individuals with OCD to be subjects in their research studies. About five hundred families have already volunteered; unfortunately, that is not enough. According to Dr. Pauls, at least three to four times that number of families is needed. If you have not signed up to be part of a study, please consider doing so. You have a chance to give of your time to help locate the gene marker for OCD.

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How We Treat OCD

Treating Adolescents with Severe OCD: Disentangling

Thröstur Björgvinsson, Ph.D., and Constantina Boudouvas, LCSW
Menninger OCD Treatment Program
The Menninger Clinic
Houston, TX



Although The Menninger Clinic offers specialty hospital treatment for both adolescents and adults with OCD, in this article we want to talk about the philosophy and some of the specific treatment strategies used to treat adolescents with severe OCD. While the evidence-based treatment technique, exposure and ritual prevention (ERP), is similar for both adults and adolescents with OCD, we have found it necessary to make several modifications to meet the specific

developmental needs of adolescents.

At The Menninger Clinic we offer specialized hospital care for up to eight adolescents at any given time. Our treatment program is designed to help adolescents who are not able to make significant gains in outpatient treatment and whose functioning is so impaired that it is impacting all aspects of

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Bulletin Board

Body Dysmorphic Disorder Study

People with body dysmorphic disorder (BDD) worry about their appearance, thinking there's something wrong with how they look. BDD usually begins during childhood or adolescence but very little is known about what treatments help this age group. Research is greatly needed to answer this important question. We are studying the effectiveness of the medication fluoxetine for children and adolescents ages 10-16 with BDD who qualify for our study. This study is being done by BDD experts at the Mount Sinai Medical Center in New York, NY (Dr. Eric Hollander), Butler Hospital/Brown Medical School in Providence, Rhode Island (Dr. Katharine Phillips), and The University of Cincinnati School of Medicine in Cincinnati, Ohio (Drs. Brian McConville and Susan McElroy). People who qualify will receive free study treatment and are paid for their participation. Please contact us if you are interested in participating:

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Binghamton Anxiety Clinic Study

The Binghamton Anxiety Clinic at SUNY Binghamton is conducting research that examines predictors of OCD symptom change. Specifically, our research team is currently conducting a series of studies examining whether specific types of beliefs and life stress predict increases in OCD symptoms over time. Research has shown that OCD is associated with particular types of beliefs, such as overestimating responsibility and an intolerance of uncertainty. In addition, current theories of OCD propose that these types of beliefs and stress may contribute to the development of OCD. However, the role of these factors in the development of OCD remains largely untested. Research at the Binghamton Anxiety Clinic is now testing

whether these factors contribute to increases in OCD symptoms. A better understanding of modifiable risk factors for OCD will greatly facilitate the development of programs aimed at preventing the development of full-blown OCD. For additional information call the Binghamton Anxiety Clinic at 607-777-5006 or contact Dr. Meredith Coles at mcoles@binghamton.edu.

Clinic Patients Wanted in Florida

The University of Florida OCD Program features a comprehensive pharmacological and cognitive-behavioral treatment program for children, adolescents, and adults with OCD. The UF OCD Program has an extensive outpatient treatment program as well as an intensive day treatment program.

Contact: UF OCD Program at 352-265-8362 or email: DrGoodman@psychiatry.ufl.edu. Website: www.ufocd.org

Have You Been Diagnosed with Obsessive Compulsive Disorder (OCD)?

Are you currently taking medicine for OCD but have found little or no relief from your symptoms?

If your answer is "yes," you may qualify for a no-cost research study designed to evaluate the effectiveness of adding a marketed medication for investigational use to a Serotonin Reuptake Inhibitor (SRI) in the treatment of OCD. Eligible participants must be over 18 years of age and currently taking an SRI medication for OCD. The research study is being conducted by Dr. Eric Hollander at Mt. Sinai's Compulsive, Impulsive and Anxiety Disorders Program. For more information, please call 212-369-5123. (GCO#04-0379PS, IRB approved through 8/30/05).

Research Study of Cognitive-Behavioral Therapy for Obsessive Compulsive Disorder

The Anxiety Disorders Clinic at the New York State Psychiatric Institute (NYSPI) invites you to participate in a research study of cognitive-behavioral therapy for 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

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OCD NEWSLETTER

The OCD Newsletter is published six times a year.

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

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

OCF GENETICS COLLABORATIVE MEETS; THEIR RESEARCH CONTINUES

By David Pauls, Ph.D, Director, Neurodevelopmental Genetics Unit, Massachusetts General Hospital; Professor, Harvard Medical School and Chairman of the OCF Genetics Collaborative

The third annual meeting of the OCF Genetics Collaborative was held in Boston on May 14-15, 2005. A total of 36 investigators from seven different countries and 20 different universities attended.

On Saturday morning, investigators from the various sites presented updates on the work they had done related to the genetics of OCD since the last meeting. There has been significant progress over the last year. Members of the Collaborative published over 86 research articles in the last year alone. The topics included family studies, phenotype definition, candidate genes studies, biomarker studies and genetic linkage studies. The following is a brief summary of those studies.

Family Studies: Investigators from three different sites (Michigan, New Haven and Boston) reported on findings from studies on families of children and adolescents with OCD. The results were remarkably consistent. The frequency of OCD among first degree family members ranged from 22% to 26%. This is about twice the rate that is observed for relatives in families of adults with OCD. Thus, it seems that OCD that starts in childhood is more familial than OCD that begins in adulthood. This finding was also supported by investigators from the Paris site.

Phenotype Definition: There were also reports on the considerable amount of work that had been done on studies that had been designed to examine the OCD phenotype in more detail as well as to explain more thoroughly the relationship between OCD and other affective and anxiety disorders. Investigators from Baltimore, Boston, Utrecht in the Netherlands, and Cape Town, South Africa, reported findings suggesting that certain obsessions and compulsions occur together more often than would be expected by chance. These results replicate previous studies published by other members of the Collaborative and lead to the hypothesis that certain clusters of symptoms may have different underlying genetic mechanisms. In addition, the investigators found that individuals with OCD will often suffer from other anxiety and affective disorders, such as, panic disorder and depression. Investigators from Baltimore and Boston reported findings that suggest that the pattern of comorbidity is not random in families and may be related to some of the underlying genetic risk factors.

Candidate Gene Studies: Investigators from the Toronto, Mexico City, Paris and Utrecht sites reported the results of the research com-

pleted in their laboratories on a number of candidate genes. The genes that were examined included a glutamate (NMDA) subunit receptor gene (GRIN2B), the gamma-aminobutyric acid type B receptor 1 (GABBR1) gene, the myelin oligodendrocyte glycoprotein (MOG) gene, a serotonin receptor gene (HTR-1B), the μ opioid receptor gene, the serotonin transporter gene (5-HTTLPR), and two kainate receptors, GRIK2 and GRIK3. Each of these genes plays an important role in neurotransmission and/or brain development. It is plausible that one or more of these genes could increase the risk for OCD. As with all candidate gene studies to date, the results were somewhat mixed. Preliminary positive results were obtained for GRIN2B, GABBR1 and HTR-1B and negative results were obtained for the others. However, all studies relied on very small sample sizes so all of these results should be viewed as tentative and in need of replication.

Biomarker Studies: Because there is evidence that suggests the involvement of autoimmune mechanisms in the pathophysiology of some individuals with OCD, investigators from the Utrecht site examined whether OCD might be associated with altered activity of the immune system. A number of different components of the immune system were examined. The investigators reported a significant increase in two of these suggesting a potential for altered immune function in the pathophysiology of OCD. In another study, this same investigative team examined the possible role of the dopaminergic receptor D2 in the manifestation of OCD. They found that there appears to be a lower level of binding of this receptor in one area of the brain suggesting that the dopamine system may play a role in the development of OCD.

Genetic Linkage Studies: One of the most exciting reports was on the progress made in the ongoing genetic linkage study centered at Johns Hopkins University with the support of researchers at the Providence, New York, Washington, DC, Los Angeles and Boston sites. The first report was of a replication of a linkage on chromosome 9 first reported by investigators from the Michigan site. Replication of results is the hallmark of science. Thus, this represents a very important step in our understanding of the genetics of OCD. The second report provided the current state of a genome-wide scan on a large sample collected by investigators from the six sites mentioned above. At the time of the meeting, the data were still being analyzed so the final results could not be reported. Nevertheless, the preliminary results were very exciting.

I'd like to interject a comment here. It is important to note that it is only because of the

generosity of hundreds of families across the world in donating their time (and blood) that these studies have been possible. All of the investigators in the OCF Genetics Collaborative want to express our heartfelt thanks to all of the families who participated. Tremendous progress has been made, but much more work needs to be done.

On Saturday afternoon, David Altshuler, M.D., Ph.D., Associate Professor of Genetics at Harvard Medical School and Molecular Biology at Massachusetts General Hospital, gave a lecture entitled "Genome sequence variation and the genetic analysis of complex traits." The lecture focused on how the genetic study of OCD could progress more quickly by using the ever expanding methods being developed in the field of genomics.

On Sunday morning, Shaun Purcell, Ph.D. Assistant Professor of Psychiatry at the Harvard Medical School and a faculty member in the Psychiatric and Neurodevelopmental Genetics Unit at Massachusetts General Hospital, gave a lecture entitled "Study designs for detecting and dissecting genetic influences on complex traits and diseases." This lecture focused on the analyses of data generated by the methodologies described by Dr. Altshuler.

The lectures were followed by considerable discussion as to how best to apply these approaches to the genetic study of OCD. The conclusion of those discussions was twofold. First, there is a need for much larger samples of individuals with OCD and their families. At the present time, the members of the group have data (clinical and genetic) from approximately 500 families. In order to achieve our goal of understanding the genetics of OCD, at least 3 to 4 times that number of families will be needed. Second, there is also a need to find alternative ways of raising funds for this research. Because of the downturn of funds from the National Institutes of Health and the resulting decrease in the amount of grant funds for extramural research, it is becoming more important to solicit funds from philanthropic donors.

It is important to understand that studies of the magnitude described above will require large sums of money. One estimate is that it would require approximately \$10 million over the next 3 to 5 years to achieve the goal of finding genes for OCD. This is where the Collaborative and the OCF can work together. Many members of the group are willing to speak to groups of prospective donors (assembled by the OCF or by OCF members) to describe the work that is being done and the promise that new methods hold for future progress. We have made a great start and I am enthusiastic about the future. However, to be successful, we will need large numbers of families to participate in our studies and enough funds to complete the studies successfully.

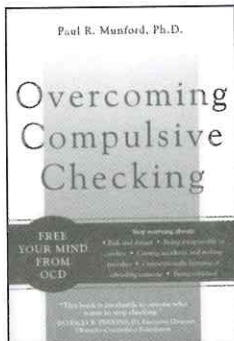
Book Review

Overcoming Compulsive Checking

by Paul Munford, Ph.D.

Director, Anxiety Treatment Center of
Northern California, Sacramento, CA

Reviewed by Jonathan Grayson, Ph.D., The
Anxiety and Agoraphobia Treatment Center,
Bala Cynwyd, PA



OCD can have an infinite number of faces. Rather than trying to cover every possible OCD symptom, Dr. Munford's "Overcoming Compulsive Checking" provides targeted self-help advice for

those suffering from compulsive checking. Of course, numerous rituals have the possibility of being considered checking, so Dr. Munford immediately helps prospective readers to decide whether or not this book is for them by describing the three categories of compulsive checking that his book addresses. They are: 1) safety fears, e.g., preventing future disasters such as fires by checking the stove; 2) fear of harming others, e.g., a mother checking to make sure she hasn't added detergent to her baby's food or a driver circling the block in his car to make sure he hasn't run over someone and left him there; and 3) fear of embarrassment, e.g., a student checking and rechecking her writing to make sure there are no mistakes that might make her look careless or stupid or a man constantly sniffing his underarms to make sure his body odor isn't offensive.

You can't begin to work on a problem you don't understand. The first two chapters of "Overcoming Compulsive Checking" are devoted to helping sufferers understand the nature of OCD and the treatment process. Through clear and simple language, Dr. Munford identifies OCD as an anxiety disorder that has at its core the fear of the improbable. But fear does not listen to logic, so he warns readers against trying to simply view OCD as irrational thoughts that can be argued with because that won't work. Using description, research and case examples, Dr. Munford explains how readers can overcome their fears of uncertainty.

In chapters 3 and 4, Dr. Munford moves from explanation to action. Sufferers are urged to assess their OCD using the tests and forms he provides in the book. Then he gives an overview of what he believes is the core of psychological treatment for OCD – exposure, ritual prevention and awareness therapy (ERPA). Many practicing therapists refer to this type of behavior therapy simply as ERP, exposure and response (ritual) prevention. Dr. Munford adds awareness to emphasize that when you are exposing yourself to your feared triggers (e.g., driving by schools for those with hit and run fears), it is important to have your attention focused upon your fears, thoughts, bodily sensations and imagined consequences. He carefully describes the mental rituals and traps that sufferers can fall into that will undermine treatment. For example, many sufferers may try to distract themselves during exposure. Not only does this interfere with exposure; but the effort not to think about the obsessional fears actually results in the sufferer paying more attention to them and missing the therapeutic benefits that come from doing exposure properly.

Chapters 5, 6 and 7 are devoted to describing exposure exercises for each of the checking compulsions Dr. Munford identified in the introduction (safety, fear of harming others, fear of embarrassment). In each chapter, he discusses the different variations of that chapter's type of checking. For example, in the chapter on the fear of harming others, he includes obsessional fears of running people over and poisoning baby food. Dr. Munford's concern and care for sufferers are apparent throughout the book, but especially in these chapters. He knows that treatment can be hard, so he discusses different ways to structure ERPA so that a sufferer can set his/her own pace for proceeding from the relatively easy exposures to the most challenging ones.

The final chapter of the book briefly discusses potential obstacles to treatment that are under the sufferer's control, the role the family can play and the importance of maintaining the gains. With regard to families, he gives the critical advice that families need to ask how they can help rather than simply to try to

impose their will on the situation. Dr. Munford urges family members to be cheerleaders for any successes. He also advises them against participating in rituals or providing reassurance and explains why these actions are harmful. While it is true that reassurance undermines ERPA, one should keep in mind that the sufferer needs to be involved in determining when and how the family is going to disentangle itself from the sufferer's OCD. Also, it has been my experience that unilateral decisions by family members to stop checking for the sufferer can be met with bitter anger. So any family members considering such action will need a very carefully crafted plan to help them cope with the stress that can result.

Obviously, no book can be perfect and I would be remiss not to note the few problems that I had with the book. I agree totally with Dr. Munford that irrational fears cannot be argued away. However, throughout the book he provides subtle reassurance to sufferers, such as describing OCD fears as false fears. The implication is that they don't have to be worried about. I'm not sure I see the difference between this and trying to rationalize fears away.

Although it is very important for sufferers to start with exposures that they can carry out, many of the exposures suggested by Dr. Munford are more focused upon changing rituals as opposed to actual exposure. Even when he suggests exposures, they are often far milder than what some of my other colleagues and I would have clients do. To me his exposure advice contradicts an important point he made in the final chapter: treatment needs to be complete to avoid slips and relapses.

These issues, however, should not be considered major flaws in this book. "Overcoming Compulsive Checking" offers those who suffer from compulsive checking well-thought out concrete advice in an easy to read book. This work is obviously based upon a combination of Dr. Munford's clinical experience, research and his genuine concern for the welfare of his clients. If you have the issues discussed in the book, then "Overcoming Compulsive Checking" can help you to free yourself from OCD.

My OCD Notebook

Mental Gardening: Crowding Out OCD Weeds *

By *Ginger E. Blume, Ph.D.*
Middletown, CT

When unimpeded, OCD tends to grow like a wild and hearty weed in the mental landscape of the OCD sufferer. The illness can quickly dominate a fertile mind (genetically predisposed field), leaving little space for the flowers and trees of life to flourish. Many of the techniques described in this article are akin to digging up weeds by their roots (altering one's mental assumptions by making them more conscious). Of course, weeding a garden is not much fun, but the long-term results are certainly rewarding.

For 27 years, I've met with clients day after day in my private practice office and have heard many themes repeated again and again by the clients who suffer with OCD. Since there are many excellent articles on using cognitive-behavioral or exposure and response prevention strategies, this article will focus on those significant themes that are sometimes ignored in treatment.

Theme #1: OCD forces a focus on past and future time frames.

Whether obsessing about what I did (past) or what I might do (future) that is bad/wrong, the mental time frame of the OCD sufferer is stuck in the past or the imagined future. Theoretically and practically speaking, it is nearly impossible to be engaged in obsessions or compulsive rituals when we are living fully in the present moment. When we stay in the here and now, we literally shut off the oxygen supply to OCD. It cannot survive in the "here and now."

Implication for Wellness: Focus on living fully in the "here and now." This conscious shift in mental focus creates an antidote to OCD. Various strategies help us to do this, such as, gestalt therapy awareness exercises, meditation, mindfulness practices, yoga, etc.

Theme #2: OCD forces a focus on what I "do not want" versus on what I "want."

OCD thoughts thrive in a mental landscape of one's "not wants." These "not wants" are typically expressed in thoughts such as, "What if I forgot to shut off the water and the house is flooded?" The

OCD mind is focused on various fears about possible unwanted events and outcomes (illness/harm to others/blasphemous thoughts).

The non-OCD individual is more often motivated by "wants." These "wants" are like an internal compass, helping guide one toward what is wanted in life. We naturally notice what the mind is thinking about. For example, we've all had the experience of purchasing a new car (i.e., a Saab) and suddenly, noticing all the Saabs on the road that we never observed before. When we scan the world on a daily basis for our "wants" versus our "not wants," we're more likely to obtain our "wants" and be happy.

Implication for Wellness: Focus on what you want, not what you fear or don't want. For instance, if I'm aware that I want to get to work on time, I must focus on "keeping moving" versus staying to check and recheck the house. In other words, the "wants" in our mind are an antidote to OCD "not wants."

Theme #3: OCD forces a focus on "certainty" versus "shades of gray."

Woody Allen wisely observed that the only thing we can be certain of is death. When he used the word "certain," he meant something we can know without a shadow (shade of gray) of a doubt. In reality, there are so few certainties that to live a life searching for them is ludicrous; and yet, isn't that what the OCD illness would have us do? OCD sufferers never consider shades of gray when it comes to life. For instance, the OCD demands that we be "sure" about our advice to our children. Then, we become so inhibited because of the fear of saying something wrong that we say nothing. As a result, one's entire life is a series of serious black or white decisions and outcomes with no room for reasonable life circumstances.

Non-OCD thinkers experience the world in relative terms filled with numerous shades of gray. For instance, in principle, I am against stealing. However, if an infant were dying and I had exhausted other ways of obtaining food with no success, I would feel morally required to steal food for the infant's survival.

Implication for Wellness: Role-play with your therapist or coach being able to recog-

nize reasonable shades of gray in your life. This involves learning to identify outcomes that are "good enough" (a shade of gray) versus holding out for "perfect."

Theme #4: OCD forces one to accept no risks.

In reality, educated risks make life juicy (a shade of gray) versus too dangerous (black or white). In reality, we can't do anything without acknowledging that the act of living is about risks. Risks come in various forms, but they also allow for joy. Observe an infant playing peek-a-boo. The risk of not finding mother after she disappears is balanced by the joy of finding her again and again. Through this simple game, the infant is unconsciously learning that some risks are fun. Not all risks are terrible and catastrophic.

Implications for Wellness: Seek out risks that have the potential of bringing joy to your life.

Theme #5: OCD focuses on possibilities, not probabilities.

OCD obsessions and compulsions derive some of their bizarre quality from the fact that OCD doesn't distinguish between possibility and probability. Obsessions and compulsive behaviors occur because the OCD mind says, "This could happen," or "What if this happens." The OCD mind is focused on "pure possibilities." But, while most anything is possible, how probable is it? Again, due to black and white thinking, the OCD sufferer often feels justified in worrying about something that is possible, yet highly improbable, because s/he doesn't consider the shade of gray that probability implies.

Implications for Wellness: The concept of probability can be used in a graduated fashion to help clients slowly eliminate questionable obsessions and compulsions. Clients can be asked to carry out their OCD compulsion only if the probability of unwanted consequences is 40% or better, hence eliminating a lot of doubt. Then, clients can be asked to eliminate those compulsions with only a 25% or better probability of "X" occurring, etc. The probabilities are jointly chosen by the therapist and client based on an educated guess of likelihood of "X" occurring (with room for moving downward over time).

Summary:

These five themes are all helpful mental frames for structuring a preparation for effectively overcoming one's OCD. They honor the fact that as human beings, we have a need to "understand why." When

Research Digest

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

This Research Digest presents a potpourri of results with unusual treatments for OCD.

Double-blind treatment with oral morphine in treatment-resistant obsessive-compulsive disorder

Journal of Clinical Psychiatry, 66:353-359, 2005, L.M. Koran, E. Aboujaoude, K.D. Bullock et al.

Mu-opioid receptor agonists, a group of medications that include morphine, tramadol and naloxone, have shown some effectiveness in treatment-resistant OCD. In this study, 23 patients with treatment-resistant OCD were randomly assigned to 2-week blocks of once-weekly morphine, lorazepam (Ativan) and placebo. Each patient was rotated, on a blinded basis, through all three treatments. Dosage at week 2 of each block was increased, decreased, or maintained depending on response and side effects. For morphine, week 2 dose ranged from 15 to 45 mg; for lorazepam, 0.5 to 2 mg. All medications were administered in a clinic and responses to medications were evaluated weekly. Seven of the 23 patients were responders to morphine. The highest morphine doses were 30 mg for 4 responders and 45 mg for 3 responders. No morphine responder took morphine alone; medications being taken prior to the study had been continued. Interestingly, only 1 of 7 patients taking an atypical antipsychotic responded to morphine. Morphine responders described the relief of OCD symptoms as being noticeable the day after taking morphine and lasting 2 to 5 days. The most frequent side effects reported for morphine were sedation, dizziness, nausea and fatigue; no euphoric effects were noted. These results suggest that morphine may be helpful for individuals with treatment-resistant OCD. Further study is needed, looking at both the effectiveness of morphine and other mu-agonists and at substance dependence issues with these medications.

Mirtazapine for obsessive-compulsive disorder: an open trial followed by double-blind discontinuation

Journal of Clinical Psychiatry, 66:515-520, 2005, L.M. Koran, N.N. Gamel, H.W. Chung et al.

Mirtazapine (Remeron) is an antidepressant that increases both serotonin and norepinephrine release. The mechanism by which it enhances serotonin function differs from that of selective serotonin reuptake

inhibitors (SSRIs). In this 12-week open trial, 30 subjects (15 treatment-naïve and 15 treatment-experienced) with OCD received mirtazapine starting at 30 mg/day and dosed over 2 weeks as tolerated to 60 mg/day. At week 12, responders to mirtazapine were randomly assigned to continue mirtazapine or switch to placebo for 8 weeks. Sixteen patients (53.3%—8 treatment-naïve and 8 treatment-experienced) were responders. The double-blind discontinuation part of the study suggested that the clinical response in the open trial phase was not a placebo response. The severity of OCD in the placebo group markedly increased in the discontinuation phase, while the severity of OCD in the mirtazapine continuation group significantly lessened. Side effects of mirtazapine led 17% (5 of 30 patients) to discontinue the study. Most side effects experienced were mild to moderate, such as sedation. As in depression treatment studies, a significant number of patients (32%) had a weight gain of $\geq 7\%$ of starting weight. Researchers conclude that mirtazapine may be effective for OCD and further study is worthwhile.

Nicotine augmentation for refractory obsessive-compulsive disorder. A case report

Progress in Neuro-Psychopharmacology & Biological Psychiatry, 29:157-159, 2005, M. Pasquini, A. Garavini and M. Biondi

A case is presented of a 31-year-old male patient with OCD resistant to conventional treatments. His current medications, clomipramine (Anafranil) and valproate (Depakote), were augmented with 4 mg nicotine chewing gum. After 4 weeks of treatment, the patient and his relatives were very enthusiastic about the results and his Yale-Brown Obsessive Compulsive Scale (Y-BOCS) score had decreased from 38 to 23. He was treated for an additional 3 months without reporting side effects and the addition of nicotine to his treatment allowed a reduction in clomipramine and valproate doses. Researchers discuss possible mechanisms for nicotine's effects, including effects on brain neuroregulators and on memory function. They conclude that their observation of beneficial effects of nicotine augmentation on a single patient is interesting but inconclusive.

Herbal hazards: which psychotropics interact with four common supplements

Current Psychiatry, 4(1):16-18,23-25,29-30, 2005, C.F. Edie and N. Dewan

Many individuals self-medicate with herbal

remedies. In fact, one-third of Americans in a recent national survey reported using complementary treatments and dietary supplements. Here authors review effectiveness and safety of ginkgo biloba, St. John's wort, kava kava and valerian. A few key points relevant to OCD and OCD medications follow. Ginkgo biloba is promoted primarily for dementia, cerebrovascular dysfunction and memory enhancement. Bleeding complications can occur, so ginkgo should not be taken with warfarin and caution is urged if it is taken with aspirin. Ginkgo may interact with fluvoxamine (Luvox) and fluoxetine (Prozac). St. John's wort is used to treat depression and anxiety. The greatest concern with St. John's wort is the high number of drug-herb interactions. Interactions might result in serotonin syndrome with symptoms of restlessness, sweating and agitation. St. John's wort has been reported to interact with buspirone (BuSpar), paroxetine (Paxil), sertraline (Zoloft) and venlafaxine (Effexor). Given the high risk for drug interactions, authors do not recommend St. John's wort use in patients receiving any other medications. Kava kava is used by some patients to treat anxiety and insomnia. Reports have associated kava kava use with liver toxicity and failure. Because of its effects on the liver, kava kava can increase levels of and potential adverse effects of any medication metabolized by the liver. Reviewers say avoid kava kava use because of the substantial risk of liver toxicity and drug interactions. Valerian is promoted as a treatment for insomnia and anxiety. Common side effects are headache and morning drowsiness. Because of its sedative effects, caution is urged if individuals drive while using it. The recommendation to physicians is monitor patients using valerian for adverse effects and drug interactions.

Bupropion for patients with obsessive-compulsive disorder: an open-label, fixed-dose study

Journal of Clinical Psychiatry, 66:228-230, 2005, N.C.C. Vulink, D. Denys and H.G.M. Westenberg

Bupropion (Wellbutrin) is used for depression and social anxiety disorder. Differing from SSRIs that affect serotonin uptake, bupropion acts prominently through other brain chemicals, dopamine and norepinephrine. In an 8-week trial, 12 OCD patients received bupropion extended release, starting dosage of 150 mg/day increased to a maximum of 300 mg/day. No other psychotropic drugs were administered.

Research Digest

Bupropion was not an effective treatment for OCD. In combining patient results, there was a nonsignificant small decrease in Y-BOCS score. Four patients improved (only 2 could be qualified as responders) and 8 patients deteriorated. The finding that some patients experienced a substantial worsening of OCD symptoms is of interest. Researchers speculate on the role of dopamine in OCD.

Deep brain stimulation for refractory obsessive-compulsive disorder

Biological Psychiatry, 57:510-516, 2005, J.L. Abelson, G.C. Curtis, O. Sagher et al.

Neurosurgery (capsulotomy or cingulotomy) has been beneficial for many patients with severe, non-responsive OCD; but the irreversibility of the procedure is an important limitation to its use. Electrical deep brain stimulation (DBS) uses electrical currents to the same brain areas surgery targets, at levels too low to produce tissue destruction. DBS for OCD was examined in four patients in a short-term, blinded, on-off design and long-term, open follow-up study at the University of Michigan. The patients had severe OCD and had not responded to at least four medication trials and a cognitive-behavioral therapy trial. The stimulator hardware was surgically implanted, with leads placed bilaterally in the brain in the anterior limbs of internal capsules. Patients received stimulation in a randomized "on-off" sequence in four 3-week blocks. Stimulation was continued in consenting patients after the controlled trial. Dramatic benefits to mood, anxiety and OCD symptoms were seen in one patient during the blinded study and in the open follow-up. A second patient showed moderate benefit during the open follow-up. There was little effect on OCD symptoms in the other two patients. These results are comparable to neurosurgery results. Discontinuing stimulation in the patient with a good response was accompanied by an acute lowering of her mood, suggesting a risk of worsening depression with cessation of stimulation. This is a concern in that possible breaks in leads or depletion of batteries could cause cessation of beneficial stimulation. Researchers conclude DBS shows promise, but they do not believe that it is sufficiently well developed at present to replace traditional neurosurgery as the treatment of choice for severe, treatment-resistant OCD patients.

The role of venlafaxine in the treatment of obsessive-compulsive disorder

Annals of Pharmacotherapy, 39:136-140, 2005, N.J. Phelps and M.E. Cates

This is a review of the published literature on the use of venlafaxine (Effexor) in the treatment of OCD. Successful treatment of OCD with venlafaxine has been reported in case reports, open trials and comparison trials to clomipramine (Anafranil) and paroxetine (Paxil). The only placebo-controlled trial (Yaryura-Tobias JA, Neziroglu FA, Venlafaxine in obsessive-compulsive disorder (letter). *Archives of General Psychiatry* 53:653-654, 1996) did not find significant improvement with venlafaxine and reported that a longer length of treatment at higher doses may have been needed. Reviewers conclude that while venlafaxine may be considered another medication option in the treatment of OCD, it has not shown any unique advantage over currently recommended medication (SSRIs).

Antibiotic prophylaxis with azithromycin or penicillin for childhood-onset neuropsychiatric disorders

Biological Psychiatry, 57:788-792, 2005, L.A. Snider, L. Lougee, M. Slattery et al.

Streptococcal infections can trigger the onset or worsening of OCD and tic disorders in children. This is referred to as PANDAS (pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections). Researchers hypothesized that the prevention of streptococcal infections among children in the PANDAS subgroup would decrease OCD and tic symptom exacerbations (increase in symptoms). Twenty-three children with PANDAS were enrolled in a double-blind study. Antibiotic prophylaxis (preventative treatment) with penicillin or azithromycin was administered for 12 months. Occurrence of streptococcal infections and OCD/tic symptom exacerbations were compared between the study year and the baseline year (prior to receiving antibiotic). Both penicillin and azithromycin prophylaxis were found to be effective in decreasing streptococcal infections and OCD/tic symptom exacerbations among children with PANDAS. Based on concerns of decreasing effectiveness of azithromycin prophylaxis from other studies, it should not routinely be recommended for children with post-streptococcal neuropsychiatric disorders. Researchers suggest that penicillin prophylaxis might be considered for children who meet all criteria for PANDAS and who have ongoing risk of streptococcus infections.

Mental Gardening

(continued from page 5)

OCD has been a way of life for a significant period of time, it is painful and risky for the individual to restructure his/her understanding of life (i.e., some of the mental models of reality must change). Too often an OCD sufferer is identified with his/her OCD; when in reality, the OCD is a disorder separate and apart from the sufferer. It can be best imagined as a weed in the sufferer's fabulous garden. OCD sufferers are "not their OCD," but rather, "have OCD."

Oftentimes, therapy is primarily focused on the severe anxiety caused by OCD. This article is designed to acknowledge the pain of reorganizing one's understanding of life in all its complexity. Rather than rely on our clients taking a "leap of faith" and following our treatment directives, we can help ease their path by providing the assumptions behind our treatment recommendations.

I've come to view the OCD sufferer's faulty assumptions as invasive weeds that crowd out normal functioning in the garden of life. Because these weeds are genetically hardy and programmed to dominate the mind, sometimes, they are all that is visible upon first glance into the individual's life. Once the garden is weeded, both the client and I jointly discover the previously hidden beauty of his/her garden. Treatment allows the sufferer's talents and creativity that were previously sapped of their strength and energy by the OCD "weeds" to thrive.

Warning: These themes are not a substitute for carrying out daily change strategies. Most of us would agree that it is nearly impossible to learn how to ride a bike by simply hearing or reading a book of instructions. No matter how much talking about the principles of bike riding one does, you must actually get on the bike and locate your own internal sense of balance in order to successfully ride. It is the same with managing OCD symptoms. You can discuss strategies until you are blue in the face, but ultimately, you must do it! You must put into practice via action resisting or not giving into the OCD compulsive urges.

Dr. Blume is a practicing psychologist and life coach with offices in Middletown, CT

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UNIVERSITY OF FLORIDA H

The following is an interview with Dr. Eric Storch of the University of Florida Department of Psychiatry about its Child Obsessive Compulsive Disorder Treatment Program.

NEWSLETTER: There has been an OCD treatment program at the University of Florida for adults for quite a while, when did you open your Child Obsessive-Compulsive Disorder Treatment Program?



DR. STORCH: Our adult program began after the arrival of Dr. Wayne Goodman at the University of Florida's Department of Psychiatry in 1993. Our child program opened in 1999 due to the success of the adult program and

the incredible need for such a center in the southeastern United States. Within the past several years, we have made considerable efforts to increase our patient capacity – for both adults and youth – in both our intensive outpatient and weekly OCD treatment programs.

NEWSLETTER: Are there age limits for children to be in the program? What are they?

DR. STORCH: We have seen children as young as four years old and adults across the lifespan.

NEWSLETTER: Will the Child Obsessive-Compulsive Disorder Treatment Program be devoted completely to the treatment of OCD or will other anxiety disorders affecting children be treated there?

DR. STORCH: Although we specialize in the treatment of OCD, we are open to and able to serve all children with anxiety disorders. The intensive outpatient program, however, is specific to individuals with OCD, as the intervention is tailored to treating this disorder.

NEWSLETTER: What treatments for OCD are used at the University of Florida Child OCD Treatment Program? CBT? Medication? Psychotherapy?

DR. STORCH: We believe in an integrated approach in the treatment of children and adults with OCD that includes CBT and medication management.

NEWSLETTER: Why do you consider CBT (cognitive behavior therapy) as the first line treatment of OCD?

DR. STORCH: We believe that the available scientific evidence strongly supports CBT as the first-line treatment for OCD in both adults and children. For example, the recent POTS trial published in the Journal of the American Medical Association concluded that CBT alone or with concurrent medication is the first-line treatment of choice for children and teens with OCD. Among adults, a recent study by Dr. Edna Foa and her colleagues concluded that CBT was superior to medication treatment alone; thus, CBT alone or with medication should be considered the first-line approach. We strongly believe in an integrated approach to treatment, stressing a combination of both treatment modalities when appropriate in order to meet the needs of each individual.

NEWSLETTER: When would you use medication as part of the treatment of a child in your program? What kind of medications do you use?

DR. STORCH: We are fortunate to have wonderful program psychiatrists in Drs. Tanya Murphy and Wayne Goodman who understand the roles of both pharmacotherapy and CBT in treating people with OCD. Medical management is based on the unique qualities of the child (or adult) and his/her family. Obviously, not every person requires medication. In general, we believe that medications specific for OCD are useful for moderate to severe OCD, when anxiety or depression are too severe to allow for a trial of CBT, or when CBT alone has not resulted in sufficient improvement in symptoms. Treatment of comorbid conditions with appropriate medications, such as a stimulant for ADHD, may also improve CBT outcomes. Medications for OCD would include serotonin reuptake inhibitors. The FDA-approved medications for pediatric OCD would be considered first line. Augmentation strategies with other classes of medications are considered after CBT and two trials of SSRIs have not been successful.

NEWSLETTER: Is the purpose of the University of Florida Child OCD Treatment Program to do an assessment of children who might have OCD or is it a treatment program?

DR. STORCH: Both services are provided within our program, though most individuals are seen for treatment. For those entering treatment, an extensive assessment is conducted prior to treatment and upon completion. For those interested in assessment only, we offer a comprehensive day-long assessment that includes a clinical interview, diagnostic interview, clinician-rated instruments of OCD severity, behavioral observations of relevant symptoms, cognitive ability and aca-

ademic achievement testing, and numerous parent, teacher, and child report measures. Based on the obtained results, recommendations are made to families that cover a range of areas (e.g., treatment, school, social life, family).

NEWSLETTER: What tests or measures are used to determine if a child has OCD?

DR. STORCH: We conduct an extensive assessment before and after treatment for each person. For children, this assessment includes a clinical interview with myself or Drs. Murphy or Geffken, structured diagnostic interview, the Children's Yale-Brown Obsessive-Compulsive Inventory, and various parent, teacher and child-report questionnaires. For adults, the process is quite similar. With permission, we attempt to gather information from multiple informants, including the patient, his/her spouse, and other significant relations.

NEWSLETTER: How do you decide whether to use only CBT or CBT plus medication with a particular patient?

DR. STORCH: Medications are a reasonable option in combination with CBT for moderate to severe OCD. With mild OCD, CBT is the first choice. For some cases of severe OCD, medication may be required as a first-line treatment to improve the chance of success with CBT.

NEWSLETTER: Who will be staffing the Child Treatment Program? Can you give our readers some indication of each member of the team's educational background and experience?

DR. STORCH: We have a large staff of clinical psychologists, psychiatrists, clinical psychology postdoctoral fellows, psychology interns, and research assistants. In the OCD program, patients receiving CBT are seen either by clinical psychologists or advanced clinical psychology interns under the supervision of a licensed clinical psychologist. All therapists – whether a licensed provider or intern – have extensive training and experience in CBT with children, adolescents, and adults with OCD. Clinical psychology interns also receive frequent supervision by myself and Dr. Gary Geffken, and are required to observe others' treatment sessions before they provide actual treatment.

Our team also has extensive experience in working with obsessive-compulsive spectrum disorders such as trichotillomania, Tourette's Syndrome, and body dysmorphic disorder. We take pride in our team's ability to deal with more refractory cases.

CHILDREN'S OCD PROGRAM

Drs. Goodman and Murphy have conducted extensive research in treating intractable cases through medication management, while Dr. Geffken and I have studied the treatment of such cases using CBT. We also have expertise in working with children with Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS).

NEWSLETTER: Is a treatment plan done for each child when they first come to the program? Who is involved in creating the child's treatment plan?

DR. STORCH: Based on a comprehensive assessment, an individualized treatment plan is made for each child when s/he comes to the program. Each child's plan is developed by the psychology team treating the child. The creation of all treatment plans are led by licensed clinical psychologists, including Dr. Geffken and I, who have research and clinical expertise in the cognitive-behavioral treatment of child and adolescent (and adult) patients with obsessive compulsive disorder. Drs. Murphy and Goodman direct pharmacological treatment components. We believe in a multidisciplinary approach and, thus, meet frequently as a team to discuss cases.

NEWSLETTER: Is your program for children a residential program or an outpatient program?

DR. STORCH: We offer both an intensive outpatient treatment program, as well as more standard weekly cognitive-behavioral treatment. Since we do not offer an inpatient program, we help families traveling from long distances secure hotel reservations at nearby extended-stay facilities.

NEWSLETTER: Does an enrollee in your Children and Adolescent OCD Treatment Program attend sessions every day with a behavior therapist? How long is each session?

DR. STORCH: Patients in our program are seen either by clinical psychologists or advanced clinical psychology doctoral candidates under the supervision of a licensed clinical psychologist. All therapists – whether a licensed provider or doctoral candidate – have extensive training and experience in CBT for OCD. For the intensive program, sessions are held every weekday and last 90-minutes. Additionally, people are given an average of 90-minutes of homework to complete outside of their scheduled therapy sessions. For the weekly program, sessions are held once per week and last approximately 60-75 minutes. Again, patients are assigned homework to complete outside of the therapy session.

NEWSLETTER: Is there a set time period for a patient's treatment in this program? How many weeks is it?

DR. STORCH: In the intensive program, patients are seen each weekday for an average of three weeks. Sometimes families need more or less treatment depending on the symptom severity or the family's comfort level in dealing with symptoms independently. We are always able to accommodate accordingly. Sometimes we schedule additional intensive sessions and other times patients finish the program early. After finishing intensive treatment, patients are typically followed by a cognitive-behavioral practitioner near their home. In the outpatient weekly program, families are seen for an average of 14 weeks. Again, some children are ready to finish therapy sooner or later than others; we simply adjust to the needs of the individual.

NEWSLETTER: How many treatment sessions does a patient have every week? How long do the sessions last? Does he or she get homework to do?

DR. STORCH: In the intensive program, patients are seen each weekday for an average of three weeks. Sessions last 90 minutes and people are given an average of 90 minutes of homework to conduct independently. Individuals in the weekly program are seen once per week for a 60-75-minute session, and the patient is given homework assignments designed to span the period before his/her next session (i.e., one week). We strongly believe that independent homework assignments facilitate improvements by helping the patient develop skills to deal with obsessions and compulsions. In short, these assignments help a person to master the skills they have learned during the previous CBT session.

NEWSLETTER: Are your treatment plans individually designed so that if a child needs a longer period of treatment, he or she will be allowed to stay in the program until reaching a point that the OCD is under control and does not interfere with the patient's daily living?

DR. STORCH: OCD symptoms are extremely heterogeneous in nature with symptoms covering a wide range of domains. Given this, an individual treatment plan is developed for each person at the start of treatment. There is tremendous flexibility with regard to meeting the individual's needs. For example, we are always able to extend the course of therapy should it be needed. Other accommodations are also made to meet a patient's individual needs. For example, if one's symptoms are specific to the

school or home environment, we make every effort to conduct school-based or home-based sessions.

NEWSLETTER: Does your program service only children who live within driving distance of the clinic or do you have arrangement for patients that come from farther away? Are there hospital beds for them or do they need to make arrangements at a local hotel?

DR. STORCH: Both the adult and child programs serve people from all over the world. We have had families come from Europe and South America to receive treatment, as well as many from most of the states in the US. Although we do not offer an inpatient program, we help families traveling from long distances secure hotel reservations at nearby extended-stay facilities. There is also the options of the nearby Ronald McDonald House and local religious organizations to ease the financial burden of temporarily relocating to Gainesville, Florida.

NEWSLETTER: Are parents and the children themselves involved in setting the treatment plan?

DR. STORCH: Parents and children (and family members if appropriate) are included extensively in determining the treatment plan. If children do not "own" their goals, there may be less effort made towards achieving them. With parents, our approach incorporates a "Parent as Therapist" model. In other words, we believe that if parents know the theory, nature, and treatment of OCD, then they will be effective figures in maintaining gains and preventing relapse. This education starts in the first session with both parent and child – we provide extensive education about OCD and CBT for OCD. In addition, following Dr. John March's protocol, we help children view OCD as the "enemy" – an enemy that can be beaten with a little work.

NEWSLETTER: Are there group sessions where the children can work together with their peers on CBT?

DR. STORCH: This depends on the needs and wishes of the family, as well as the clinical value and practicality. Regarding the latter points, many families in the intensive program come from great distances – it is simply not practical to bring other peers to our facility. When appropriate, however, we have held group sessions with a child and his/her siblings, cousins or friends. Such sessions have focused on teaching peers about OCD, how to help the patient fight symptoms when they are together, and problem-solving ways to deal with difficult childhood situations (e.g., bullying). In addition, we

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UFL's Children's OCD Program

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have also incorporated peers to help further develop social skills and, in general, provide support for children. Many children in our program have benefited from having siblings attend treatment sessions with them in order to provide these peer-related interactions and support.

NEWSLETTER: Are there other groups where the children can address other problems they experience because of the OCD?

DR.STORCH: Although we do not offer therapy groups for people with OCD, many patients do enjoy connecting with others who also have OCD. Upon request and appropriate consent, we are happy to link families together to discuss problems related to OCD.

NEWSLETTER: If a child has a comorbid condition can s/he participate in your program? Will there be treatment for the comorbid condition?

DR.STORCH: A strong "yes" to both. There are times where a comorbid condition may warrant attention prior to the OCD, for example, psychosis or disruptive behavior disorders. In such cases, we address the problem either prior to beginning CBT (e.g., medication management for psychosis) or concurrently in treatment (e.g., helping families deal with oppositionality), according to our clinical acumen about which would be the most appropriate and effective strategy for each individual case.

NEWSLETTER: Will parents or family members be taught how to be behavior therapy coaches while the child is in the program?

DR. STORCH: Absolutely. We typically include parents and family members in all aspects of treatment. Our approach incorporates a "Parent as Therapist" model. In other words, we believe that if parents know the theory, nature, and treatment of OCD, then they will be effective figures in maintaining gains and preventing relapse. When necessary, we will work with school personnel and other necessary individuals in order to help the patient improve.

NEWSLETTER: It's been determined that a child's classroom teacher can be an effective behavior therapy coach. Will the treatment providers in your group consider dealing with a teacher who is interested in helping the child with his/her CBT?

DR. STORCH: With parent and child consent we allow any caregiver of the child (e.g., teachers, relatives, a nanny) to participate in the child's treatment. When teachers have asked to be involved in the past, at minimum we have consulted with the teacher by phone and provided written educa-

tional material about CBT for OCD. We also communicate the child's behavioral goals and coping strategies to the teacher as the child's therapy progresses. When a teacher is able to attend a session with the child and the child's family, we welcome the opportunity to have the teacher observe the therapy and ask questions about implementing CBT in the classroom. Occasionally, schedules permit conducting the therapy session at the child's school, where we have engaged the child in an exposure during class for teachers to observe.

NEWSLETTER: Will the children be trained how to recognize a relapse and be taught how to deal with it?

Dr. STORCH: Absolutely. From the onset of treatment, our patients are taught to identify obsessive thoughts and compulsive behaviors. We also discuss the relationship between compulsive behaviors and maintenance of OCD symptoms. After they understand these basic concepts we ask them to guide their own therapy and make decisions about the things they should be working on outside of the therapy sessions. Prior to completing treatment, we pose future challenges to our patients and ask them to identify three things: 1) how to address an obsession through cognitive "talking back," 2) what to do if they realize they have been engaging in compulsive behavior, and 3) how to know if s/he needs a therapy "booster shot." We want each patient to articulate in a developmentally-appropriate way, his/her understanding that s/he should: 1) try to use cognitive strategies to address the anxiety and refrain from engaging in the compulsive behavior, 2) stop the compulsive behaviors in the future and perhaps set up some exposure exercises, and 3) return to treatment when steps one and two are not working, and preferably before things get so bad that the patient feels overwhelmed or out of control.

NEWSLETTER: What kind of follow-up will be done for these children? Will the members of your treatment team be willing to consult with the child's regular treatment provider?

DR. STORCH: We strongly advise patients to continue with follow-up care after completing an intensive treatment course. Patients who live in the area can continue treatment at our clinic on a more intermittent basis (e.g., weekly). Those who live greater distances away are either followed through phone contact or are referred to cognitive-behavioral practitioners in their area. Should that person not have adequate experience in treating OCD, we are happy to provide phone supervision for the clinician as needed. Given the wide disparity in number of clinicians with expertise in CBT for OCD and patients in need, providing phone supervision is a common occurrence. Within our approach, we highlight relapse prevention and maintenance of treatment

gains throughout sessions. We make every effort to educate our patients about factors that can contribute to a relapse during and after intensive treatment.

NEWSLETTER: Is there scientific evidence that supports your program of using CBT as a first line of treatment? Is there research that promotes the use of both CBT and medication?

DR. STORCH: Both our child and adult programs have strong empirical support, facts that make us very proud. We are completing a trial with children comparing intensive versus weekly therapy schedules. Overall, about 80% of children in both the intensive and weekly programs responded very well to CBT with symptom reductions of about 60-70% on average. We have found very similar results in our adult patients. Perhaps most striking, however, is the tremendous improvement we see in our patients' daily living. Our patients report improved functioning in school, work, and social life.

NEWSLETTER: Are the services and treatment that your group provides covered by private insurance, Medicare or Medicaid?

DR. STORCH: Our services are covered by some private insurances, though unless there is a set dollar amount benefit for mental health services to be used by the patient, it will generally involve pre-certification. Medicare covers our services within the constraints of Medicare regulations in a teaching hospital. Unfortunately, Medicaid does not cover services by psychologists in Florida.

NEWSLETTER: Are there any scholarships or programs that will help families who cannot afford the treatment at your program? What are they?

DR. STORCH: There are a number of ways we can make treatment more affordable for families in need. Regarding housing, some families have stayed at the Ronald McDonald House, which is within walking distance to our facility. At the House, families of children receiving care at the University of Florida are able to stay at a comfortable, supportive residence near our facility. In return, families are asked to make a donation ranging from \$5 to \$20 per day; if that isn't possible, their stay is free. Participating in research is another way that we can cut the costs for families. For example, we are able to conduct assessments and evaluations at no cost for participating families. Finally, we are able to offer a 20% discount to those families who do not have insurance to cover treatment costs.

NEWSLETTER: With whom should a parent get in touch if s/he thinks your program would be good for his/her child?

DR. STORCH: Families can contact me directly at (352) 392-3611 or by e-mail at estorch@psychiatry.ufl.edu.

Do You Need An Educational Consultant?

By Sara Finney, MS, LMFT, and Dr. George Posner, CEP

When families seek help for a child who is struggling with OCD, they often retain the assistance of professionals within their community, such as, psychiatrists, psychologists, therapists and tutors who can work with the child and family on an outpatient or intensive outpatient basis. For many young people, this level of intervention and support might be adequate. However, in some cases, professionals and family members come to the conclusion that a more intensive treatment environment, such as a residential treatment program or therapeutic school is required to meet the specific needs of the child. When the need for an out-of-home placement occurs, the family should consider retaining the assistance of an experienced special-needs educational consultant. Doing so can prove to be an invaluable resource for both the child and family.

Special-needs educational consultants are professionals whose expertise lies in knowing the best residential treatment programs and therapeutic boarding schools around the country. They specialize in advising families regarding the most appropriate settings for children with psychological, social, learning and behavioral issues. They are able to advise families based on their knowledge of a wide range of schools and programs.

As in other professions, educational consultants vary greatly in terms of backgrounds, experience, and standards of practice. The best special-needs educational consultants have visited and assessed hundreds of specialty schools and programs around the country and abroad. They make ongoing site visits, spending time evaluating the type of clients each placement serves and the quality and extent of the programming (i.e., therapeutic, academic, residential, recreational, etc.), learning the philosophy and treatment approaches offered, becoming familiar with key professionals who are directly responsible for client care, and interviewing students in the program or school to get their perspectives. Ongoing site visits are important to maintain up-to-date information about new and evolving options for children and families and about the current peer group at each facility.

In addition to site visits, the best educational consultants often follow the progress of the children they place through an ongoing relationship with the school throughout the child's stay. They

do this in order to maintain a clear understanding of the child's issues, treatment goals and progress; the strengths and weaknesses of each facility, including the way they solve problems; the kind of dedication they show to the children and families they serve; and the amount of turnover typical in each setting, etc. They also confer with other special needs educational consultants throughout the country to hear their feedback and experience with schools and programs. This provides the very important information that families need to know before making a huge financial and emotional commitment to a particular school or program.

Before making a recommendation, an educational consultant works with the family and allied professionals to gain a comprehensive view of the child and his or her needs. Typically, consultants start with a parent interview, either in person or over the phone. When possible, they also interview the child. They speak with the professionals who have worked with the child, such as, psychiatrists, therapists, and teachers, to get their perspectives and recommendations. They review any testing or evaluations that have been done, as well as school transcripts, samples of writing or other projects. Once the initial information is gathered and reviewed, the consultant begins to match the type of setting required based on the information provided by the professionals and families. First, the consultant determines the level of therapeutic intensity and degree of specialization and focus on treating OCD. Then the consultant eliminates schools that don't meet the specific clinical or academic needs of the child. Other factors considered include the potential peer group at the school, the experience of primary therapists, the academic program offered, degree of individual versus group therapeutic focus, level and sophistication of family therapy required, and the importance of small, nurturing environment, special services offered, etc. Of course, program quality and reputation are always considered along with outcomes the school or program has had in the past with similar students.

Once the list of possible schools is narrowed down, the consultant presents the child's case to the admission teams, so that they can familiarize themselves with the case and discuss such things as fit, options for therapists, and availability, etc. With this final information at hand, the consultant introduces and educates the parents about the top options, helping

them to understand the strengths and weaknesses of each. The consultant should be able to offer the top choices to families with specific explanations to support his/her opinions. At this point parents are encouraged to contact the program or schools directly. They are also encouraged to visit their top choices to solidify their understanding of what they offer, and also what the expectations for parents will be if they enroll their child.

An important point for families to consider during this process, is that, as mentioned above, there is an extremely wide range of schools and programs available for children with special needs, including residential diagnostic centers, therapeutic outdoor programs, residential treatment centers, clinical or therapeutic boarding schools, emotional growth boarding schools, and traditional boarding schools. Because of the many options available, it is essential, especially when placing a child with OCD, to choose the option most appropriate for the child. A good educational consultant can help the parent with these choices, including the category of school and best option within that category for each child. A more detailed article explaining the various options available and what they offer children with special needs is available on our website: www.gposner.com/articles.

Finally, anytime parents come to the conclusion that their child might need an out-of-home placement, there can be a great deal of stress, feelings of guilt and failure, and immobility. Educational consultants can help the family think more clearly about this process and about the most appropriate options. In this way, parents can feel more confident about their child's treatment, education, and, ultimately, future.

For more information on choosing a reputable special needs educational consultant, refer once again to our website: www.gposner.com/articles.

Sara Finney, MS, LMFT, and Dr. George Posner, CEP, are educational consultants specializing in private residential placements for children age 7-25 with psychological, social, learning and behavioral problems. Ms. Finney, a clinical member of AAMFT, spent 10 years as an adolescent and family therapist in a variety of private residential schools and programs prior to joining Educational Consulting Service (ECS). Dr. Posner, who founded ECS eleven years ago, is Professor Emeritus at Cornell University.

Treating Adolescents with Severe OCD: Disentangling Symptoms from Family

(continued from page 1)

psychosocial functioning, including family, school, and friends. Our nursing staff is trained in cognitive-behavior therapy and knows how to aid our clients in exposure and response prevention. Our program has licensed nursing staff available 24 hours a day to meet patient and family needs.

Because many of our adolescents are either still enrolled in school or have been unable to attend due to the severity of their symptoms, we have an accredited school on campus that works with patients and their families. The treatment team strives to integrate school into each patient's individual treatment plan because this provides a unique opportunity to practice specific treatment interventions. Cognitive-behavior therapists work with the teachers to create an exposure and ritual prevention plan for patients in an effort to help our adolescents attend school upon returning home.

Those of you living with an OCD sufferer know all too well the many subtle ways OCD can undermine family routines and relationships. When we opened our doors for adolescents more than four years ago (April 2001), we redefined the treatment team to include the parents. The patient has always been considered a part of the treatment team at Menninger; and on our unit, we extend that paradigm to include family members. A treatment goal for each patient is to mobilize all family members in disentangling the OCD from family interactions. To achieve this, the family must be actively involved in treatment.

Family Involvement

Family involvement in treatment begins at the time of assessment and continues through the course of treatment. The cognitive-behavior therapist and psychiatrist meet with the adolescent and his or her family to gather information about the history of patient and family functioning. One of the measures we use is the Family Accommodation of Symptom Scale, an assessment tool and a method to gain a quantifiable measurement of family accommodation of OCD symptoms (see Calvocoressi et al., 1999). Parents often report feeling a sense of relief when we ask questions about OCD behaviors they have been engaged in as they try to mitigate their son/daughter's anxiety. The assessment phase helps us create a baseline from which the patient and family can begin the work of extricating the family from OCD rituals and accommodations.

Education is the first step in effectively empowering families and diminishing anxiety. As co-collaborators in the treatment pro-

cess, the family is involved in behavior planning and family therapy through weekly conference calls (or face-to-face meetings whenever possible) with a cognitive-behavior therapist. We've found it helpful to have one meeting or phone call a week without the patient for the purpose of sharing information and helping to coach family members in appropriate responses to OCD behaviors. In addition, we conduct one phone call a week that includes the patient to discuss any issues that have come up in the parents' individual calls with their son/daughter during the week. This allows us to begin to pinpoint areas in family relationships that have become entangled with OCD rituals.

Studies have demonstrated that too much accommodating and/or antagonistic responses decrease the chances of recovery (see Van Noppen and Steketee, 2003, for discussion). Recent evidence (e.g., Chambless & Steketee, 1999) also demonstrates high Expressed Emotion as a potential predictor of poor treatment outcome in anxiety disorders. Based on this research, we try to help families reduce their antagonistic and/or other responses that may inadvertently reinforce the OCD behavior in their son or daughter. It is understandable that living with this chronic illness in isolation and without treatment can be quite frustrating and exhausting for the entire family.

We have found that when family members have better coping skills they are better able to respond in a helpful and supportive manner. We emphasize the importance of self-care for parents when they are acting as caregivers. There is a positive correlation with decreased Expressed Emotions in family members. We encourage them to get connected with advocacy groups such as the OC Foundation and NAMI. We also encourage them to take vacations they may have put off, rejoin their spiritual community activities, return to work if possible and engage in normal family activities.

A unique and important feature of the program is a bimonthly, full-day family workshop that enables families to provide support and share resources with each other (see Table I below). Due to the enormous strain OCD symptoms often put on all family interactions, family members are strongly encouraged to attend the workshop at no additional charge.

Families and adolescents who have participated in the family workshop have told us how important and helpful the workshop has been in increasing their understanding of OCD-related struggles, and how it has empowered both the adolescents and their

family members. An encouraging by-product of this workshop has been the spontaneous creation of family network and support groups. This includes parents of adolescents as well as spouses and other family members of adult patients. The creation of family support groups such as these has significantly reduced the feeling of "alienation" and "isolation" for families as they are seeking out resources available to them at local, state and federal levels.

Table I - Menninger Full-Day Family Workshop

8:30-8:50	Breakfast and introduction (families and OCD staff)
9:00-9:30	Meeting with cognitive-behavioral therapist (adolescents & families)
9:30-10:30	Treatment Contract Review (adolescents, families and all OCD staff)
10:30-11:30	Cognitive-behavioral approaches in treating severe OCD (Dr. Thröstur Björgvinsson)
11:30-12:30	Psychopharmacological and medical issues in treating OCD (Dr. Joyce Davidson)
12:30-1:30	Lunch
1:30-3:00	OCD (family members only - Constantina Boudouvas, LCSW)
3:15-4:45	Working together in overcoming OCD (adolescents and families - Constantina Boudouvas, LCSW)

Specific Challenges with Adolescents

There are times when family members may feel that their child is being manipulative and controlling for the sake of "getting his or her way." We are often asked: "How do we know whether or not this behavior is adolescent rebellion or OCD?" The way that we handle this in our treatment program is to assume both. We emphasize that in order for us to be able to foster "a culture of change to challenge the OCD," there are certain things that we will not accommodate. We encourage parents to begin to enforce expectations, that is, to begin to expect the teenager to complete normal household chores, not to accept disruptive household behaviors, and so forth. Because their son or daughter is now in a treatment program, the parents now have the opportunity to discuss these changes. No member of the family will be taken by surprise; expectations have been communicated and are out in the open.

The fact that adolescents are living within a community during their treatment at The Menninger Clinic forces them to adapt to living with others. They are no longer able to control their environment. Many in our

program have learned how to do their own laundry and have adjusted to other family operating rules and normal OCD-free household habits.

Based on the fact that OCD sufferers have so many rules, our philosophy of treatment is to create the least restrictive environment possible. This is an area where treatment for adolescents differs somewhat from that of adults with OCD. Our experience has shown us that because of their developmental phase, some structure for adolescents is both supportive and therapeutic. Our adolescent population is given the opportunity to earn varying levels of progressive responsibility, i.e., the opportunity to walk around the campus by themselves, go off campus with staff into the community, and have higher degrees of freedom in areas related to getting to and from appointments and school on their own.

Treatment Approach

Our treatment approach toward OCD is evidence-based and rooted in cognitive-behavior therapy. Our focus is on trying to help OCD sufferers who have failed in other forms of treatment whether the treatment has been outpatient, intensive or gradual and self-directed. We work with adolescents who are struggling with extremely severe symptoms and who are also often failing in school. The centerpiece of treatment is supporting the adolescent to "stay the course" – to do the difficult work that is required to be effective.

Additionally, it is imperative to educate the entire family about how OCD entangles the family and give family members ways to support the teenager in treatment. We focus on helping parents be just that: parents. We strive to create an atmosphere for change that enables the adolescent to complete his or her exposures, to achieve habituation and to reduce symptoms. This culture of change comes from a unique blend of support and encouragement received from fellow OCD sufferers that is complemented with feedback from the interdisciplinary treatment team. The psychiatrist, as part of the team, closely monitors the medication efficacy, if medications are prescribed, and makes recommendations for different medication trials when warranted.

The functional assessment sets the stage for the development of a hierarchy of OCD triggers. From this, a preliminary treatment plan is created. The patient's answers to questions such as "What is the obsession?" and "What triggers your OCD?" drive the plan of action and help determine what exposures are to be focused on first. From this, a general guide of the progression of the treatment is created. The essence of each person's individualized plan informs the ongoing treatment process.

After assessing an adolescent's OCD triggers and fears, with input from the family, a more formal plan is created – the Behavior Treatment Plan. This "road map" for treatment delineates the hierarchy, core problems, specific obsessions, compulsions, avoidances, goals and specific interventions. This is a fluid and flexible plan that continues to evolve throughout the course of treatment. Usually therapists, with input from parents, have adolescents start with low to mild anxiety-producing OCD triggers – often around 4 to 5 on an anxiety rating scale that ranges from 1 to 10. In our experience, which is supported by research evidence, difficult exposures need to be repeated daily for the best results. Consistency and response prevention is very important in order to give the adolescent the opportunity to experience mastery over his or her OCD triggers. To facilitate this, the Behavior Treatment Plan contains information and a plan of action that addresses ways our 24-hour staff can assist adolescents through their morning and evening routines with a minimal of rituals. It also is a roadmap for implementing staff-assisted exposure and ritual prevention sessions. Both staff and adolescent are responsible for the integrity of the exposure and ritual prevention sessions.

The treatment community

The treatment community (also called the milieu) is very powerful in instituting change and motivating adolescents who previously have been unable to complete ERP sessions. Interventions for challenging OCD symptoms applied in the treatment community include providing a safe physical environment, ritual blocking by staff, support and understanding of peers and staff, education, group and teamwork, camaraderie, containment, and, if needed, 24-hour supervision. This blend fosters the culture of change, while maintaining a safe treatment community where adolescents and staff work collaboratively toward treatment goals.

Treatment interventions and group work are naturally based on the diagnosis and symptoms of each patient. To do this, our staff has created several diagnostic-specific and symptom-specific groups. Adolescents often comment that these groups are particularly helpful. This format provides a unique opportunity to create support and reduce the false beliefs adolescents often hold about the nature of their symptoms.

The cornerstone of the Menninger OCD Treatment Center is the daily 90-minute ERP sessions and the minimum required number of self-directed ERP sessions. The ERP sessions take place in a group, but each exposure exercise is completely individualized. We use group in the sense that the adolescents gather in a group and report their "SUDS" (anxiety rating or "subjective units of

distress score) at the beginning of the session, as well as working out who needs individual staff support in blocking his/her rituals or implementing his/her ERP exercise. At the end of the ERP session, the adolescents get together as a group and report their highest SUDS score of the session, their current SUDS score, and their successes in implementing the ERP exercise for that day.

Summary

It is very clear to the Menninger treatment team that alliance and collaboration are essential for effective treatment. We ask adolescents to face what they fear most and to live with uncertainty. The aim is to support the adolescent patient as s/he independently complete ERP sessions resulting in habituation and symptom reduction. The best way we have been able to create such alliances is through genuine empathy, education through the CBT model, practice, and reliance on the treatment community or peers to convince those who are just entering treatment that success is possible. Self-efficacy (i.e., the belief that one can successfully complete an ERP session) is enhanced through peer persuasion and the vicarious experience of seeing others effectively mastering their OCD symptoms. This enhancement of self-efficacy is best achieved, we believe, when it occurs in a group of individuals facing similar challenges. So far, our data are convincing in demonstrating the effectiveness of this approach in helping many adolescents who have not been successful in less intensive treatment programs.

The mission of the specialty hospital program at The Menninger Clinic is to create a culture of change in which an OCD sufferer is surrounded by a caring and understanding staff that has empathy for his/her struggles in an effort to support effective implementation of ERP sessions. Equally important are the sufferer's peers, who not only provide a special form of empathy, but are often the source of the most intense challenges to the most resistant of OCD symptoms. This culture of change is very different from the culture of helplessness that sufferers often find themselves in. Frequently, family members and other caregivers are exhausted and do not have the wherewithal to adequately support treatment efforts. Coming to a specialty hospital provides sufferers with a "fresh start" in a new context. Many sufferers have been socially isolated and struggling with debilitating OCD for years and are experiencing major changes in their lives (both physical and emotional). In these situations, psychosocial treatments that are aimed at treating the whole person are beneficial.

Dr. Björgvinsson may be reached at 800-351-9058, ext. 5420, or via e-mail, tbjorgvinsson@menninger.edu. The Menninger OCD Treatment Program Website is at <http://lmenningerclinic.org/p-ocd>.

Research Grants

(continued from page 1)

Treatment Response in OCD to Sertraline and Aripiprazole as Compared to Sertraline and Placebo

Presently, for many people with OCD, the SSRI medications that are used to treat OCD are not effective. It is Dr.

Bystritsky's contention that adding one of the new atypical antipsychotics, in this case Aripiprazole, to an SSRI, Sertraline, will increase the overall effectiveness of the SSRI against OCD symptoms. In this study, one group of patients will be given Sertraline and a placebo and another group Sertraline and the atypical antipsychotic, Aripiprazole. This will be done as a double blind study with neither the investigators or patients knowing which group is getting the Aripiprazole and which group will be getting the placebo. One retrospective study has looked at Aripiprazole as an augmentor of an SSRI in the treatment of mood and anxiety disorders. In that study, 10 out of 17 patients with depression and various anxiety disorders who had a limited response to the SSRI alone, responded to augmentation by Aripiprazole. This trial will be the first one conducted on individuals with OCD.

Carrying out the study in this way will allow Dr. Bystritsky and his team to determine whether the combination of an SSRI and an atypical antipsychotic produces a more pronounced and/or more rapid improvement in OCD symptoms than an SSRI alone. Dr. Bystritsky is anticipating that this study may help determine the tolerability and clinical utility of starting treatment with both an SSRI and an atypical antipsychotic and will prove that augmenting an SSRI with an atypical antipsychotic will significantly help patients with OCD by more quickly and thoroughly alleviating and eliminating obsessions and compulsions. Presently, many OCD patients are either responding partially or not at all to SSRIs taken alone.

Cytokine Levels and Genes in Childhood OCD: a Longitudinal Study

What is known now is that OCD affects 1-2% of children and adolescents causing them significant problems in school, at home and in social situations. While medication and cognitive-behavior therapy have been successful with some children, they do not work well on all children and adolescents who have OCD. It appears that treatment has been more

effective for children with OCD whose etiology is an autoimmune response, as is the case with PANDAS. This type of OCD in which the symptoms wax and wane is called "sawtooth" OCD. OCD that does not appear to be related to an autoimmune response is chronic and is characterized by a non-fluctuating symptom course.

In this project, Dr. Grados and his team will follow 20 children with OCD who have previously been involved in a genetics study at Johns Hopkins. One part of the work will be classifying the course of each child's symptoms as either chronic or "sawtooth." They will also be looking at Cytokine levels in these children and whether or not they vary in "sawtooth" or chronic OCD. Cytokines are chemical messengers of the immune system and are altered in the inflammatory processes. In this study, Dr. Grados wants to prove that there are genetically different types of OCD.

D-Cycloserine Augmentation of Exposure and Response Prevention Treatment for Obsessive-Compulsive Disorder

Exposure and response prevention therapy (ERP) has been found to be an effective treatment of OCD in adults. Unfortunately, it does not help every person with OCD and some of the people it helps only have a partial reduction of symptoms. Thus, the search must continue for treatments that are effective for OCD. Procedurally, ERP therapy is based on two components, namely, conditioned fear and extinction. On a neural level, ERP incorporates similar mechanisms to those involved in fear conditioning. Antagonists at the N-methyl-D-aspartate (NMDA) glutamatergic receptor, which is involved in learning and memory, are thought to block fear learning and extinction. According to Dr. Storch, this study's principal investigator, there is evidence that suggests that D-Cycloserine (DCS) helps extinction learning in animals and humans and thus, may, as an addition to ERP, help behavior psychotherapies that are based on extinction principles.

Dr. Storch and his team have hypothesized that DCS taken before ERP therapy sessions may enhance an OCD patient's treatment result. This study is being done to discover whether DCS enhances the short-term clinical benefits of ERP treatment given to adults with OCD.

The use of DCS to facilitate the extinction of conditioned fear could significantly

increase the effectiveness of ERP treatment. It might also prove to be a beneficial augmentation strategy for patients who are experiencing refractory OCD. Finally, this study may also have implications for other psychiatric disorders. Because behavioral treatment of other anxiety disorders incorporates exposure-based techniques, DCS may be beneficial as an adjunctive treatment strategy.

Genome-Wide Association of OCD in an Isolated Population

According to Dr. Knowles, who is a member of the OCF Genetics Collaborative and is very active in genetics research, OCD is a "complex" genetic disorder and gene mapping has not been very successful in this type of disorder. The use of isolated populations has been suggested as a way to overcome the problems with genetic mapping for "complex" disorders.

In this study, Dr. Knowles, working with Dr. Dan Stein in South Africa, is proposing to collect DNA from a group of people of Afrikaan descent who have been diagnosed as having obsessive compulsive disorder and also from a group of South African Afrikaaners who do not have OCD. The DNA will be analyzed by recently developed molecular techniques for evidence of gene(s) related to obsessive compulsive disorder. It is Dr. Knowles' hypothesis that the Afrikaaners with OCD will have detectable allele frequency differences when compared with Afrikaaners without OCD; and this will occur near the genes that predispose individuals to OCD. Dr. Knowles says that using isolated populations has been successful in mapping disease genes for schizophrenia and he hopes it will also work for the genes related to OCD.

Improving Treatment Outcome in Obsessive Compulsive Disorder: Does a Motivational Enhancement Intervention Boost Efficacy?

Dr. McCabe says that while exposure and response prevention (ERP) is considered the "gold standard" psychological treatment for obsessive compulsive disorder, there is still a significant portion of individuals who do not achieve full symptom reduction after being treated with a full course of ERP therapy. There are also a number of factors that hinder the effectiveness of ERP including treatment refusal, treatment drop out, and limitations in generalizing treatment gains outside of the therapist's

office. Evidence demonstrates that even after an adequate course of ERP treatment, OCD symptoms tend to persist at moderate levels of severity. ERP is an active treatment that requires considerable commitment and involvement from the individual with OCD. If the individual is not ready to engage in treatment, then ERP treatment gains may be severely limited. Other evidence suggests that readiness for treatment and willingness to do the treatment are good indicators of whether treatment is going to be effective or not.

In response to these findings, Dr. McCabe and her colleagues at St. Joseph's Healthcare proposed in their grant request to add three sessions of motivational enhancement (ME) to ERP therapy. ME therapy utilizes motivational interviewing, a client-centered, directive method for enhancing intrinsic motivation to change. This approach was developed by W.R. Miller and S. Rollnick and is outlined in their book "Motivational interviewing: preparing people for change." The three sessions of motivational enhancement that Dr. McCabe's group is going to add will utilize the motivational interviewing approach to validate and process the patient's treatment concerns and discuss the costs and benefits of changing (i.e., undergoing ERP to alleviate symptoms) with the goal of increasing the patient's readiness for change.

In this study, there will be a group of patients who receives three one-hour sessions of motivational enhancement therapy and a control group of patients who will receive three one-hour sessions of relaxation therapy. Relaxation therapy was selected as a control due to its limited effectiveness for treating OCD. All participants will then have 15 sessions of individual ERP. According to Dr. McCabe, it is expected that the participants receiving the ME intervention prior to starting ERP will have greater improvement in OCD symptoms, lower rates of relapse in follow up, and fewer dropouts relative to those who had the relaxation therapy.

According to Dr. McCabe, this study has important implications for improving the current psychological treatment for OCD. The results of this study will give mental health providers information about the utility of implementing a brief motivational enhancement prior to beginning ERP. Dr. McCabe expects that by addressing patients' concerns, examining the costs and benefits of change and enhancing commitment to treatment, patients will be more receptive to ERP and thus have a better treatment outcome.

Your Thoughts Revealed: A Challenge from Dr. Grayson

Jonathan Grayson, Ph.D., The Anxiety and Agoraphobia Treatment Center, Bala Cynwyd, PA

Have you ever wondered how different or how similar you were to other OCD sufferers or how other sufferers cope with their lives? At the GOAL support group meeting run by the Philadelphia Affiliate of the OC Foundation, one of the most important parts of the meetings (besides picking exposure and response prevention goals to work on) is "the question." At every meeting members are presented with a question about OCD to discuss. In this way, every meeting provides us with an opportunity to thoughtfully discuss some aspect of OCD, whether it be coping with family members, careers, faith, symptoms, or any other of the endless issues OCD gives rise to.



In this issue of the OCD Newsletter, we are introducing "Your Thoughts Revealed," a place where you can share your thoughts

and feelings about a topic or question and discover how your fellow sufferers feel. In each issue we will pose a question for you to respond to. Your responses will appear in the next issue of the newsletter. Obviously, we won't be able to publish everyone's submissions and we may have to edit what we receive. But we will attempt to provide you with a representative sampling of the mail and e-mail that is sent in.

In addition, when it might be helpful, I will comment on your thoughts and provide a professional view of whatever issues were raised. We know we won't be able to do this perfectly, but no one is spared from living with imperfection and uncertainty.

Which brings us to this issue's question. OCD has an infinite number of presentations whether it be issues regarding contamination, checking, symmetry, violent thoughts or anything else a person could possibly fear. Despite all of these manifestations, OCD is a single disorder and there is a common factor: every sufferer has an area in which s/he feels the need to be absolutely, one hundred percent certain. No one can ever achieve this. Not because you have OCD, but because people with OCD are too smart. Only the unimaginative can believe in certainty. Absolute certainty does not exist; there is always some slim, infinitesimal chance that the seemingly impossible may occur. OCD is not the inability to be certain; it is the desperate anxious attempt to achieve the impossible, to be absolutely certain. Treatment is learning to live with uncertainty. With this in mind then, we are asking:

Have you or haven't you accepted uncertainty as a part of life?

What does this mean to you?

How has this affected your recovery?

Share your thoughts and feelings with the rest of the community by sending your responses by mail to the OCD Newsletter Editor, OCF, 676 State St., New Haven, CT 06511, or by e-mail to perkins@ocfoundation.org. We look forward to hearing from you.

The Iowa Support Group Model: How It's Worked for 17 Years

Donald W. Black, MD
Nancee Blum, MSW
University of Iowa, Carver College of Medicine

Nancee Blum and I started a support group for people with obsessive-compulsive disorder (OCD) in 1988 which we later described in a publication (*Obsessive-compulsive disorder support groups: the Iowa model*. *Comp Psychiatry* 1992; 33:65-71). At the time, Nancee was completing work for a MSW and had to fulfill a practicum requirement, and the two of us were involved in an OCD clinical trial, which meant that we had a steady flow of patients, most newly diagnosed. So how has the support group fared now that it is 17 years old?

Very well, thank you. With some minor modifications, the support group we described in our article still runs pretty much the same way. Either Nancee or I or the two of us are almost always present. We thought early on that the leadership of a mental health professional was essential, not only to give it staying power and to demonstrate institutional commitment, but to provide new information. We were opposed then, and now, to groups in which "the blind lead the blind." Our format is unstructured, and there is no particular agenda. Attendees bring up whatever topics come to mind. If attendees are unable to develop topics for discussion, Nancee or I suggest some, often topical to particular holidays.

There was great interest when the group started so we began with two 1-hour sessions per month. Because family members showed interest, we developed a parallel support group for them, held monthly, which one of our social work colleagues conducted. We routinely had between 8-15 attendees at the OCD groups and 5-10 at the family group.

Over time, particularly as Nancee and I moved away from clinical trials in OCD, attendance dropped off, and we felt we could only justify having one meeting per month. The family support group also went by the wayside, though for a while we invited family members to attend the patient group. The success of combining patient and family members was mixed, and we decided that to protect patient confidentiality, as well as ensure that patients felt comfortable, attendance should be confined to those with OCD.

We have never charged for the support group and do not consider it "group therapy." Initially, this raised some concerns with department administrators who felt

we should bill. But we argued that we were conducting the groups voluntarily, that people would not attend if we billed, and that in the long run it would probably pay for itself. We reasoned that the support group would help maintain patient compliance and promote clinic attendance.

The atmosphere at each support group session differs depending on who shows up. We now routinely get between 6-10 attendees, some of them regulars, with a smattering of new faces. The period of most intense involvement tends to be early on when the patients have either just been diagnosed or are entering treatment and feel they would benefit from the support of others similarly affected. In the support group setting they are able to learn about medication and behavioral therapy. Upon hearing the experience of other patients, most are reassured. Some of the patients who attend are quite ill, but others are doing very well.

Our only requirement over the years has been that the person have a diagnosis of OCD from a psychiatrist or clinical psychologist. On occasion, others have attended out of interest or concern that they have OCD, but this has never worked out. They tend to know fairly soon after the group starts that they don't fit in. If they don't know, the other attendees do. For example, we've had a number of patients with schizophrenia or schizoaffective disorder (with OCD features) who have attended; and it has become clear that their psychotic disorder predominates.

One early concern that Nancee and I had was that patients might learn new obsessions or compulsions from others and incorporate them into their illness. This concern was unfounded, and we are not aware of a single instance in which this has occurred. Our impression, and that of our attendees, is that patients view their own obsessions and compulsions as "the worst," and view other patients' symptoms as "not so bad." Another concern was that emergencies would arise and people would become highly emotional and express suicidal ideation or threaten suicidal behavior. We have had perhaps a handful of people in 17 years who have expressed suicidal feelings at the group. When that happens, Nancee or I have briefly assessed the individual following the group and encouraged him/her to contact his/her mental health professional the next day. We have never felt the patient was in imminent danger and required immediate hospitalization. Patients have almost always acted appropriately at the sessions.

The group has been an asset to our Department in the sense that it has provided a setting to train resident psychiatrists, medical students, social work practicum students, and nursing students. We encourage interested residents or students to attend as many sessions as they can to better understand the disorder and to also understand the social dynamics of support groups.

Nancee and I have greatly enjoyed our experience with the support group and are committed to continuing with it as long as patients express an interest in and a need for the group.

* Dr. Black is a member of the OCF Genetics Collaborative and Ms. Blume is a member of the OCF Scientific Advisory Board.

From the President

(continued from page 1)

The issue of funding was stressed by Dr. David Altshuler, Associate Professor of Genetics at Harvard Medical School and Molecular Biology at Massachusetts General Hospital. He spoke about how costly it was to do genotyping. And, according to Dr. Pauls, it will take approximately ten million dollars over the next three to five years to achieve the Foundation's goal of finding the gene for Obsessive Compulsive Disorder. For a full workup on one individual, it costs approximately twelve hundred dollars.

If you have not given to the OCF Genetics Collaborative yet, now is the time to consider a contribution. If you want more information on the research that is being done by the Collaborative, please contact the Foundation. Look for articles in the Foundation's newsletter that will discuss research that is being done in the area of genotyping.

Three years ago, the Board of Directors voted to fund a Genetics Collaborative. The response from investigators from around the world to be part of this group was overwhelming. For them, it was a chance to work together to help solve the mystery of Obsessive Compulsive Disorder. Each year, the investigators come closer to reaching their objective. These men and women are extremely thoughtful in their approach and determined to make it happen. We, members of the OC Foundation, must help them be successful in their quest.

I have mailed my check today and I hope that you will consider doing the same.

Best Regards,
Joy Kant
President, OCF Board of Directors

Measuring Obsessive-Compulsive Symptoms: Common Tools and Techniques

*Eric A. Storch, Ph.D.
Department of Psychiatry, University of
Florida, Gainesville, FL*

With the increased recognition of the prevalence and severity of obsessive-compulsive disorder (OCD), increased attention has been devoted to its assessment and treatment in recent years. Currently, several different methods are used to assess obsessive-compulsive symptoms, including diagnostic interviews, clinician-administered inventories, self-report measures, and parent-report measures. In fact, in the past two years, numerous OCD measures have been developed and/or published. Unfortunately, it is not possible to mention all of these; so this article is limited to an overview of measures used within our child and adult OCD clinics at the University of Florida with an eye towards what one might expect at his/her initial visit to a provider.

Diagnostic Interviews. The use of structured diagnostic interviews for the assessment of pediatric OCD is quite common in research studies (but not uncommon in general clinical practice). Diagnostic interviews can be used to assign diagnoses and differentiate between other possible diagnoses. These interviews facilitate diagnostic decisions by utilizing specific questions to assess symptoms according to Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) criteria. Within our clinic, we use the Anxiety Disorders Interview Schedule for DSM-IV for adults and the Anxiety Disorders Interview Schedule for DSM-IV: Child and Parent Versions for children and adolescents. Another commonly used interview is the Structured Clinical Interview for DSM-IV. Each of these is divided into sections by disorders. Detailed questions regarding each disorder are administered only if the preliminary criteria are found. Each interview usually takes between 60-120 minutes to administer.

Clinician-Rated Instruments. The use of a clinician-rated inventory allows trained individuals to make informed ratings of OCD-related impairment and distress in comparison to cases they have seen. Perhaps the most commonly used assessment instrument within clinical and research settings is the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) and its counterpart for children,

the Children's Yale-Brown Obsessive-Compulsive Scale. The Y-BOCS and CY-BOCS are conducted in an interview format with a trained clinician and measure OCD symptoms and severity over the previous week. The Y-BOCS and CY-BOCS consist of several parts including items querying the presence of various obsessions and compulsions and items assessing the severity of symptoms. For example, there are questions about how much time obsessions and compulsions take, as well as how much distress they cause. Scores for all items are determined by the clinician on the basis of the person's report, parent(s)/spouse's report and behavioral observations.

Self-Report Instruments. Self-report measures have several advantages in OCD assessment as they can generally be completed quickly, independently, and administered to a number of individuals at once. They are useful as screening questionnaires, and are often employed to identify potential research participants and candidates for treatment. In addition, people may feel more comfortable completing measures independently. This can guard against the under-reporting (or over-reporting) of symptoms that is sometimes observed during a clinician-administered interview. However, there are some disadvantages. For example, an individual's response style may affect his assessment of symptoms based on different interpretations of choices such as "sometimes" or "often." In addition, some respondents may have difficulty understanding the format or wording of the questionnaire, while others may not use adequate care when completing the questionnaire. Finally, the broad and variable range of symptoms in OCD may result in an underestimate of a person's impairment because specific and/or idiosyncratic symptoms may not be included in the measures.

At the University of Florida OCD Clinic, we use the Florida Obsessive Compulsive Inventory (FOCI) and the Obsessive Compulsive Inventory-Revised (OCI-R) for self-reporting of symptoms. In the FOCI is a symptom checklist and five questions that assess symptom severity and impairment. In the checklist, the individual marks the presence or absence of 20 common obsessions and compulsions (ten each).

On the severity items, the individual rates the cumulative severity of endorsed symptoms on five items: time occupied, interference, distress, resistance, and degree of control. The OCI-R is an 18-item self-report questionnaire based on the earlier 84-item OCI. Participants rate the degree to which they are bothered or distressed by specific OCD symptoms in the past month.

Besides the FOCI and OCI-R, a number of other widely used self-report instruments exist. The Yale-Brown Obsessive-Compulsive Scale-Self Report concurrently measures the presence and severity of commonly reported symptoms. The Leyton Obsessional Inventory Short Form is a 30-item self-report measure appropriate for children and adults. The presence of common symptoms is answered on a yes/no scale. The Maudsley Obsessional Compulsive Inventory contains 30 true or false items to assess the presence of common obsessions and compulsions. Finally, the Padua Inventory Revised is a 39-item self-report measure of obsessions and compulsions rated on a five-point scale according to the degree of disturbance.

Other Measures. To supplement the above measures, other questionnaires are often given. In children, it is very common for parents to rate their child's behavior on questionnaires such as the Child Obsessive Compulsive Impact Scale or the Children's Obsessional Compulsive Inventory. The former assesses the presence and severity of symptoms; the latter queries impairment related to OCD. Questionnaires about family involvement in symptoms, such as the Family Accommodation Scale (FAS), are also commonly given to family members. The FAS assesses how much others accommodated the patient's obsessions and compulsions by providing reassurance or the help necessary for completion of compulsions, decreasing behavioral expectations, modifying family activities or routines, and/or helping the child avoid objects, places, or experiences that may cause him or her distress.

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Spring BTI Was A Success!

By C. Alec Pollard, Ph.D.
Saint Louis Behavioral Medicine
Institute
St. Louis, MO

The Behavior Therapy Institute (BTI) is a training program that was initiated by the OC Foundation in 1995 to help address the shortage of psychotherapists skilled in the cognitive-behavioral treatment of OCD. The BTI was designed to provide a level of training beyond that which is typically



provided by workshops. Each BTI participant reads assigned material on the treatment of OCD, conducts an assessment of an individual with OCD, attends three days of live instruction from BTI faculty, and receives follow-up case consultation by phone from a faculty member. BTI faculty members include leading experts in the cognitive-behavioral treatment of OCD. Only licensed healthcare professionals can attend. Since the first program was held in Lakeville, Connecticut, in December of 1995, several hundred therapists from various parts of the USA and other countries have attended. In addition, a one-day advanced BTI is conducted each March cosponsored by the OCF and the Anxiety Disorders Association of America.

The latest BTI was held April 29–May 1, 2005, at the Department of Psychiatry building on the University of Pennsylvania campus in Philadelphia. Thirty clinicians traveled to Philadelphia from 20 different states and the Republic of China (Taiwan) to attend. The enrollment for each BTI is limited to 30 in order to promote an informal, interactive atmosphere and to help ensure the quality of the training. The first day of the program concentrated on the fundamentals of diagnosing, assessing, and treating OCD. This section of the BTI was taught by Dr. Edna Foa, a pre-eminent OCD researcher and clinician, Director of the Center for the Treatment and Study of Anxiety, and Professor at University of Pennsylvania's Department of Psychiatry.

The second day of the program covered special issues and populations. The first presentation was by Jeffrey Staab, MD, Assistant Professor of Psychiatry and Director of Psychiatric Services at the Hospital of the University of Pennsylvania. Dr. Staab reviewed the latest advances in

drug treatments for OCD. He was followed by Martin Franklin, Ph.D., Assistant Professor and Clinical Director of the Center for the Treatment and Study of Anxiety at the University of Pennsylvania Department of Psychiatry. Dr. Franklin discussed special considerations in treating children and adolescents with OCD. In the afternoon, Jonathan Grayson, Ph.D., and Charles Mansueto, Ph.D., reviewed the implications of comorbidity for the treatment of OCD and discussed how treatment principles are adapted for the treatment of OC Spectrum Disorders such as Hypochondriasis, Body Dysmorphic Disorder, Tourette's Disorder, and Trichotillomania. Dr. Grayson is Director of The Anxiety and Agoraphobia Treatment Center in Bala Cynwyd, PA, and Assistant Clinical Professor of Psychiatry at Temple University. Dr. Mansueto is Director of the Behavior Therapy Center of Greater Washington in Silver Spring, MD, and a Professor of Psychology at Bowie State University. At the end of the second day, I led a discussion of ways to address common practical problems (e.g., dealing with managed care, dealing with limited resources, etc.) therapists encounter as they attempt to implement CBT in various clinical settings.

On the third day, participants divided into six breakout groups to discuss their training cases and receive individual consultation from faculty. The primary objective of the third day is to refine the ability of trainees to use the cognitive-behavioral treatment model to conceptualize cases and develop individualized treatment plans. Each attendee came with a work-up for a case on which s/he was presently



working. Drs. Franklin, Grayson, and Mansueto returned on Sunday to join me as leaders of the clinical breakout groups. We were also fortunate enough to be joined by Fred Penzel, Ph.D., Executive Director of Western Suffolk Psychological Services in Huntington, NY, and Christina Taylor, Ph.D, Associate Professor of Psychology at Sacred Heart University in Fairfield, CT. Five trainees were assigned to each of the six group leaders. This gave the trainees the opportunity to learn from

four other cases in addition to their own. At the end of the program, trainees returned to their communities equipped with a treatment plan tailored specifically



for their training case.

The final step of the BTI is for trainees to implement the treatment plan developed for their training case. At the time this article was written, most cases were still being treated. The fee for the BTI includes three phone consultations with the trainee's faculty group leader. It is up to trainees to decide when they need to call their faculty consultant. Trainees in my group have had some challenging and interesting cases to discuss. When trainees complete the phone consultations to the satisfaction of their faculty consultant, a certificate of completion is awarded by the OC Foundation.

This year's BTI was well received by participants. According to one participant, the BTI "was an incredible experience and extremely beneficial....Not only did I gain a deeper understanding of the treatment process, and have an opportunity to apply it, I was able to meet others with a passion for OCD that I have." Another attendee wrote: "Reading books and manuals doesn't compare to seeing and hearing experts. All I can say is WOW. This weekend was at the top of the SUDS scale for 'AHA' experiences." As always, we also received suggestions for ways to improve the program in the future. Participant feedback is invaluable and helps us continue to improve the quality of the BTI. Some of the suggestions we received will be incorporated in the next BTI, which is planned for in Los Angeles, CA, in Winter, 2006. The Philadelphia BTI was filled to capacity and there was a waiting list. So if you are interested in attending, call Jeannette Cole, Deputy Director of the OCF, at 203-401-2069.

Dr. Pollard is the Director of the, Anxiety Disorders Center at Saint Louis Behavioral Medicine Institute and a Professor of Community and Family Medicine, Saint Louis University, in St. Louis, MO. He is a member of the OCF Scientific Advisory Board and Director of the OCF's BTI Program.

Bulletin Board

(continued from page 2)

will occur 2X per week for 2 months at the NYSPI in Manhattan); and 2) Medication and psychiatric visits. Responders will enter a 6-month maintenance phase after therapy. For more information and a confidential screening, please call 212-543-5367. (IRB#4734R).

OCD Sibling/Twin Study

Researchers in a study at the National Institute of Mental Health are looking for pairs up to age 65 where one sibling has been diagnosed with Obsessive Compulsive Disorder (OCD) prior to age 18 and looking for pairs up to age 65 where either one or both twins have been diagnosed with Obsessive Compulsive Disorder (OCD) prior to age 18. This is a brain-imaging study using Magnetic Resonance Imaging (no radiation) in Bethesda, MD.

Child Psychiatry Branch,
National Institute of Mental Health
National Institutes of Health
Department of Health and Human Services

Travel expenses and accommodations paid in full.

Please Contact:
Wendy Sharp, MSW
(301) 496-0851 or (888) 254-3823
sharpw@mail.nih.gov

Does your child or teenager take medication for OCD?

Many children and adolescents who take medication for OCD still suffer from OCD symptoms that can interfere with school, work, and relationships with family and friends.

Dr. John March, at Duke University, Dr. Martin Franklin, at the University of Pennsylvania, and Dr. Henrietta Leonard, at Brown University, are conducting a multi-site study evaluating the effectiveness of adding two different types of cognitive-behavioral therapy (CBT) to ongoing medication management for the treatment of pediatric OCD that does not respond completely to medication treatment.

Participants in this study will receive medication management free of charge. In addition, they may be assigned to receive CBT at no cost from a psychiatrist or a psychologist.

Children ages 7-17 with a diagnosis of OCD, who are taking fluoxetine (Prozac),

sertaline (Zoloft), or fluvoxamine (Luvox), and who still have residual OCD symptoms may be eligible. Children taking citalopram (Celexa) or escitalopram (Lexapro) may also be eligible.

Participants must live within commuting distance of Raleigh/Durham, NC, Philadelphia, PA, or Providence, RI.

Contact information:

Duke University, Durham, NC
Rebecca Dingfelder, (919) 416-2447,
dingf002@mc.duke.edu

University of Pennsylvania,
Philadelphia, PA
Radhika Pasupuleti, (215) 746-3331,
radhikap@mail.med.upenn.edu

Brown University
Providence, RI
Janet Ng, (401) 444-2178
jng@lifespan.org

Do You Have Obsessive-Compulsive Disorder?

Do you still have symptoms? We are conducting a research study of an investigational supplemental agent for individuals age 18-65, who have been treated for obsessive-compulsive disorder but still have symptoms. All study-related procedures and evaluations are provided at no expense. Reimbursement for participation and transportation available. For more information and to find out if you are eligible for this study, please call:

The Nathan Kline Institute
Outpatient Research Program
(845) 398-2183

Research Study on a Psychological Treatment for Obsessive-Compulsive Disorder (OCD) in Reno, NV

The Psychology Department at the University of Nevada, Reno, is seeking individuals diagnosed with OCD to participate in a study assessing the effectiveness of a psychological treatment for OCD. Specific examples of OCD include but are not limited to: checking, hand-washing, and cleaning. The study is free and will take approximately 11 hours spread over 22 weeks. There will be no cost or compensation for your participation.

If you are interested or have questions, please contact Michael Twohig, M.S., or Steven C. Hayes, Ph.D., at (775) 784-6828 ext. 2011.

Cognitive-Behavior Therapists/Psychiatrists Wanted

The OCD Resource Center of Florida is expanding services to OCD patients and families in Florida and seeks qualified, Florida licensed (or license eligible) cognitive-behavioral therapists (Masters or Ph.D.) and board certified psychiatrists to provide treatment for adults and children with OCD, OCD spectrum disorders and anxiety disorders. Locations include Orlando, and Tampa/St. Petersburg. This is an exceptional opportunity to build or add to an existing private practice. Clinical supervision will be provided. To inquire, send CV or resume via email with cover letter to:

Bruce M. Hyman, Ph.D., LCSW, Director
3475 Sheridan Street, Suite 310
Hollywood, FL 33021
Voice (954) 962-6662
Fax (954) 962-6164
Email: ocdhope@bellsouth.net

Does Your Child Have Obsessive Compulsive Problems?

- Perfectionism
- Washing
- Checking
- Dirt/Germs
- Counting
- Repeating

Is he/she already receiving medication for OCD? Your child may be eligible for free state-of-the-art therapy for pediatric obsessive-compulsive disorder at the University of Pennsylvania. For a confidential evaluation for enrollment, call (215) 746-3327.

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