



Samuel Johnson: A Patron Saint of OCD?

By Fred Penzel, Ph.D.

When I survey my past life, I discover nothing but a barren waste of time, with disorders of the mind very near to madness.

— Samuel Johnson



Dr. Penzel, shown here with his son Joey, made a pilgrimage to Dr. Johnson's home this past summer.

Having recently returned from a brief personal OCD pilgrimage while in London, I thought I would take the opportunity to share it with the OCD membership. Yes, there really are OCD shrines, if you care to look for them. This one is located in a small, well-hidden square in the heart of the City of London, just off Fleet Street. It is a place you have to really be looking for. It was the home of one of the great minds (perhaps the greatest) of the eighteenth century, a noted literary figure, and the author of the first comprehensive dictionary of the English language: Dr. Samuel Johnson. The good doctor was considered such an important figure that the second half of the eighteenth century is referred to as "the Age of Johnson." Dr. Johnson, by the way, also happened to be a person who suffered from rather serious

cases of both OCD and Tourette's Syndrome.

He was born in 1709 in Lichfield, England, just outside of Birmingham. His father, Michael Johnson, was a bookseller of modest means. He attended Oxford University, beginning in 1728, but after thirteen months was forced to drop out because he was too poor to continue. Following this, he experienced a period of depression. This is not surprising, since as an academically brilliant man, he had to end his college career simply due to poverty, while less intelligent children of the wealthy were able to continue theirs.

Johnson went on to attempt a career as a schoolmaster, but was hampered in this because he had not graduated. Also, his numerous compulsions and tics, which were quite evident, made it difficult for him to keep up a dignified appearance and earn the respect of his students.

In 1737, Johnson set out for London to make a fresh start, accompanied by one of his students, David Garrick, who would later go on to become the best-known actor/director of his time. Johnson began a literary career that would continue until his death in 1784. During that time, he produced plays, biographies, political satires, reports on parliament, works of fiction, and most notably, the most important dictionary of the English language until that time. By the time of its publication in 1755, Johnson had personally crafted over 40,000 definitions and, until the creation of the Oxford English Dictionary 150 years later, it was to stand out as 'the' dictionary. One of

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A Letter from the President

Dear Friends,

It's a dark and dreary day in January as I write this. But taking the lead from the Roman God Janus for whom this month is named, I thought I'd take a look backward to what the Foundation did last year and a look forward at what we have planned. We entered 2001 with our financial house in order and started building from there. We began the year with a board of directors strategic planning meeting where we revised the OCF's Mission Statement to encompass current issues and we identified our goals and objectives for 2001 -



In March, the board of directors awarded the 2001 OCF Research Awards to: Thomas Joiner, Ph.D., from Florida State University for "Relation of the Serotonin Transporter Gene to OCD;" Maria C. Rosario-Campos, MD, of Yale for "A Family Genetics Study of Children and Adolescents with OCD;" and Cary R. Savage, Ph.D., of Massachusetts General Hospital for "Developing a Cognitive Rehabilitation Program for OCD."

In May, we went to the American Psychiatric Convention with our new

From the Foundation

Dear Friends,

I've been arguing with myself about whether or not to write the article that follows. Obviously, by its existence, the "I" won. My hesitation has to do with the fact that though the problem is universal, I'm using this space to complain about my own personal run-in with the Healthcare System. So, for the very personal "I" in the following story, substitute yourself if you have ever had a similar experience.

I started taking an SSRI some time between December 10, 1985 and January 6, 1986. I don't know the date for sure because I was participating in a double blind study at Yale at the time. What I do know is that by mid-January of 1986, for the first time in about ten months, I was going several hours at a stretch without an obsessive thought or the unrelenting need to perform a ridiculous ritual. Things continued to get better and better and by mid-February, I was discharged and looking for a new job.

Except for a minor mishap where a pharmacist mixed up the SSRI with the placebo, I have been faithfully or fanatically (it all depends on your point of view) taking that SSRI from then to now.

For the first few years, I, along with the other people in the trials, got this medication for free. That's right. Whenever we needed a refill, we visited with one of the docs who were conducting the trials and we were rewarded with a script that instructed the Yale pharmacist to give us our medication for FREE. This was great for me. I never had to worry about whether I could get medical coverage or not, or whether I could meet my deductible expenses or whether I was going to have to pay out of pocket because of the mental illness limitation in my policy. I didn't even have to face the dilemma of deciding

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BULLETIN BOARD

The New York State Psychiatric Institute Seeks Participants for Magnetic Resonance Imaging Study

This study seeks to learn more about the causes of various neuropsychiatric disorders including OCD. The study involves taking an MRI image of the brain. MRI is a safe, painless, radiation-free way to "take a picture" of the brain. It also involves responding to questions about medical and psychological histories and completing various neuropsychological assessments. By comparing the MRI data from individuals with disorders to that from healthy control subjects, the study will help further our understanding of the neurological basis behind disorders such as OCD.

Who is Eligible?

Individuals with OCD, Tourette's, and/or ADHD as well as healthy controls between the ages of 6 and 65 are eligible.

Payment:

Participants will be compensated \$80 for their time.

Contact:

Rebecca Straus

The New York State Psychiatric Institute
Unit 74, Rm 2301
1051 Riverside Dr.
New York, NY 10032

212-543-6287

strausr@child.cpmc.columbia.edu

Note – The study will be conducted at the Yale Child Study Center in New Haven, CT, not at NYSPI.

Volunteers are Needed

Volunteers are needed for a research project being conducted in the Piedmont Triad, Charlotte and Raleigh-Durham areas of North Carolina. This project is designed to study neuropsychological factors that may play a role in OCD symptoms. Participants will be paid for their time and participation is strictly confidential.

For more information, contact Jack

Warburton, Department of Psychology,
University of North Carolina at Greensboro
(336) 256-0050.

It Doesn't Need to be a Dream: A Residence for People with OCD

Parents/guardians with a need and willingness to help, please contact volunteer planning group at gpvampire@usa.net. Planned residence will be for refractory patients needing help with activities of daily living. Planners are receiving guidance from the OC Foundation and Dr. Michael Jenike.

What Our Members Are Doing

Support Group Educates the Educators

By Bernie and Edna Bahr

Our support group prioritizes education and early on we realized that we had to "educate the educators" about OCD.



Edna and Bernie Bahr manning their booth at the Missouri State Teachers Association Conference.

Increased diagnoses in children with OCD symptoms further emphasized this need. However, it is difficult to get the attention of school personnel because there are so many demands on their

time. Several years ago, we sponsored seminars for teachers to help them better understand mental illness and its impact on their students and their classrooms. These programs (although free, well advertised and conveniently timed) were poorly attended. The feedback was: "we're too busy."

To overcome this objection and gain a captive audience, we rented a booth at the Missouri State Teachers Association 1998 Annual Meeting. We were well received and have continued to exhibit at MSTAs annual meeting. This fall we attended three conventions for teachers and school counselors. Of the thousands of attendees, we estimate that about 500 visited our booth.

The most common query: "I have a student with OCD symptoms, what should I do?" preceded many lengthy conversations about undiagnosed and untreated students as well as adult acquaintances with OCD. We supplied them with a packet of information that included: "Kids Like Me," the OCF's "Q&A" brochure, the videos from "How to Recognize and Respond to OCD in School Age Children" and a reprint of "School Personnel: A Critical Link in the Identification, Assessment, and Treatment of OCD in School Age Children and Adolescents."

The second most common query involved the difficulty in locating a trained therapist, especially in rural communities. There are many complaints about therapists who do not understand OCD. We can only offer educational materials and encourage "self-help."

The budget for these shows includes the rental of a table at the conference (usually about \$300) and the cost for travel and lodging for two days at each conference.

To address another education market segment, religious based schools, we worked directly with their administrators to update their special needs programs. We developed informational pamphlets and seminars specifically targeting the teachers, counselors and school principals from parochial schools throughout the state.

It's a great feeling to know that we have been able to help Missouri schools acquire the resources explaining serious mental illnesses and their impact on students. The fact that we continue to get inquiries tells us that school personnel are interested in learning about OCD and that they consider the information we are supplying them with to be useful.

OCD NEWSLETTER

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

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

A Little One-on-One: Jenike Reviews Schwartz' CD

Last week, I was playing basketball and had the disturbing thought while warming up that it is difficult to precisely throw a ball through the air so that it lands perfectly in a small hoop with a net that is suspended 10 feet in the air. Until I paid attention to this fact, my shots had been going in well. However, after I started to think, I had great difficulty making any shots. I think this illustrates a couple of things. We do all kinds of things automatically just fine. It is only when we start to think about and ponder automatic actions that we have difficulty functioning. I wonder if OCD could be something like this. If we just go about our business and don't scrutinize our thoughts or worry about swallowing or breathing, things go just fine.



Dr. Jeffrey Schwartz

However, just the simple act of becoming hyperaware of thoughts or automatic functions can lead to distress and a decrease in performance. Perhaps parts of our brains are designed to function best without the intrusion of our conscious cortical inputs. The non-OCD brain may have automatic ways of keeping cognitive intrusions away; and these mechanisms might be impaired in OCD. Once we have all this thinking and obsessing going on, how does one get back to basics?

One approach to manage this dilemma is discussed in a CD containing seven lectures and an epilogue by Dr. Jeffrey Schwartz, the author of the best-selling book "Brain Lock." The lectures range from about 4 1/2 minutes to 17 minutes. The technical quality of the production is excellent with no static and distortion or audience noises. All the lectures are perfectly clear in terms of audio quality. The lectures are tightly organized and Dr. Schwartz is very lucid on the points he is making.

I answer questions on Internet OCD lists, and it is clear that many patients crave something more than basic exposure and response prevention (ERP) which has been the cornerstone of OCD treatment for at least three decades now. Dr. Schwartz gives patients a richer approach to treatment, and his steps will facilitate ERP (and "mindfulness") for many patients who have mild to moderate OCD.

Dr. Schwartz' approach has been criticized by classical behavior therapists as just being a new way to look at exposure and response prevention. Also, his "allowing" the OCD patient to do some pleasurable activity ("Refocusing") rather than stay in an anxiety-provoking situation until the brain habituates has been a major source of contention. In this lecture series, he addresses these criticisms.

The first step in his process to get control of OCD is called "Relabeling." This is an activity whereby a sufferer identifies his/her obsessive thoughts, urges, and fears as being symptoms of his or her OCD. Dr. Schwartz discusses the concepts of "Mindfulness," which he describes as a function of the mind that tells you that it is the OCD that is bothering you. OCD patients attempting mindfulness need to become "impartial spectators" of their own problematic thoughts. This allows them to view their thoughts objectively and impartially as if they were someone else's. In the lecture, Dr. Schwartz acknowledges that this can only be done initially if the OCD is not too severe. If the problems are severe, he recommends that medication and CBT be used in combination with "Mindfulness."

Step 2, "Reattribution," answers the questions: "Why don't these urges and behaviors go away? What causes them?" The answer is that they are due to OCD, which is a biochemical abnormality in the brain. This is what produces the "false messages" and causes the brain to get stuck in gear.

How do you differentiate between "Relabeling" and "Reattribution"? Reattribution reminds you of the biology of the condition. OCD is due to basal ganglia malfunctioning and may be analogous to getting stuck in physical symptoms that occur with Parkinson's disease. In OCD, the orbital frontal cortex of the brain (the section above the eyes) gets hyperactive and stuck and constantly gives error feelings.

In OCD, this error detection part of the brain is stuck in gear and will not let go. Dr. Schwartz feels that this is why the feeling does not go away. It appears that medication may help this "gear shift" work better. Classical ERP seeks mainly anxiety reduction; "Mindfulness" allows more clear thinking and deeper understanding of OCD symptoms. Dr. Schwartz feels that we can use medications and ERP as a means to a greater end, that is, decreasing anxiety to allow us to develop more mindfulness and more awareness. Once you can think more clearly and be more mindful, then you increase your options tremendously. You

are now prepared to do "Refocusing" and more adaptive behaviors.

Step 3 is "Refocusing." Here is where Dr.



Dr. Michael Jenike

Schwartz introduces a new concept to counter earlier criticisms by classical behavior therapists. Their objection was that what Dr. Schwartz calls "Refocusing" is just "Avoidance." Superficially,

"Refocusing" sounds like "Avoidance." However, to Dr. Schwartz, "Refocusing" never means "Avoidance." That is a misunderstanding. It's not how you feel; it is what you do that counts! According to his theory as enunciated in the lectures, "Avoidance" is the conscious decision to avoid an anxiety-provoking situation to prevent OCD symptoms (e.g., avoiding red things because they remind you of blood). Dr. Schwartz sees the act of "Avoidance" as a compulsion. "Refocusing" actually means that instead of doing a compulsion, you do something more adaptive. You don't avoid the anxiety-provoking situation. You do a good behavior instead of doing a compulsion.

"Refocusing with a Star" is when an OCD sufferer purposefully exposes himself to a feared situation, such as, the color red. That is always good. In classical ERP, that is the ONLY thing to do. Dr. Schwartz' "Four Step" method gives other things to do as a response to OCD spikes that differs from the responses that classical BT recommends. Thus, "Refocusing with a Star" is a particularly good way (but not for beginners) to refocus one's activities on the very thing that is causing the OCD symptoms (i.e., self-exposure). I am not sure that the star adds much. It may make more sense to just use the standard terms and call this latter "Refocusing" "self-directed exposure," rather than develop still another term for the same concept. Nonetheless, Dr. Schwartz is clear about the clinical relevance of direct self-directed exposure. In Dr. Schwartz' four-step process, "Mindfulness" is also a goal; not just symptom relieving as it is in classical behavior therapy.

The final step, "Revaluing," is a deeper "Relabeling." The goal is to come to see the compulsive urge as being an OCD symptom/experience. The aim is for the person with OCD to learn not to take the

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I Think It Moved: The Understanding and Related to Sexual Orientation and R

(This is the first installment of a two-part article)

By Steven J. Phillipson Ph.D.
Clinical Director
Center for Cognitive Behavioral
Psychotherapy

Society's favorite spikes to enable

The television program is "Seinfeld." The setting is a professional office of a masseuse. One of the main characters, George Costanza, has agreed to receive the first professional massage of his life. Jerry Seinfeld has strongly recommended it saying that it will be extremely relaxing and beneficial. George is in the waiting room of this office. Expecting, and even hoping to be greeted by a young and attractive woman, he is surprised to find that his massage therapist is a large, well-built, attractive man in a white T-shirt and short pants. Although George is hesitant at first, he reluctantly agrees at Jerry's urging to go through with the massage.

In the next scene we find George leaving the office greatly flustered with a tremendous sense of urgency. He meets with Jerry for a private conversation and, with terror in his face, admits that during the massage he thinks "it" moved. Apparently, during the massage George found it relaxing yet stimulating. It seems some modicum of ambiguity was introduced as George might have experienced some initial signs of sexual arousal. As a result he became paralyzed with fear and doubt that his sexual orientation was now in question.

This comedic scenario reflects what for some OCD sufferers can be years of torment and agony. One of the more common forms of obsessional doubt involves the inability to clearly establish, with certainty, one's sexual orientation and the resultant agonizing effort to derive a conclusive answer.

Another very common obsessional doubt, which actually very often coincides with this intrusive thought (i.e., spike), is the endless effort to clearly establish whether or not the relationship one is currently devoted to is authentic or substantial enough to warrant its continuation. Do I love him enough? Is he or she attractive enough? Am I spiritually connected with this partner of mine to a sufficient degree? And finally since I might be gay, shouldn't I break up with this person and seek out my genuine self? Without too much contemplation, it is not difficult to understand why these two spikes would coincide. If a person were involved in a deeply committed relationship, and all of a sudden his predominant anxiety featured the desperate need to be absolutely clear as to what his sexual orientation entailed, questions as to the extent of his genuine love for his partner would be natural.

With the vast majority of OCD spike themes, the unreasonable and irrational nature of the spike is generally obvious. Intrusive thoughts of a mother smothering her newborn infant are usually easily recognizable as a common form of OCD or even a common intrusive thought which many new parents experience. Civilians and professionals alike are perfectly capable of identifying the irrational nature of the fear of contracting AIDs from a door knob. The terror, anguish, and felt need for an immediate resolution the sufferer experiences, with the more traditional spike themes are similar, if not identical, to relationship and/or sexual orientation spikes.

The major difference is that with these two spike themes one does not generally think of "OCD" as an initial consideration. As a result, most people with these spike themes generally have a long and painful history of seeking and obtaining fruitless guidance from others in an effort to bring a reasonable resolution to these seemingly legitimate issues. The predominant distinguishing variable, which can help determine the difference between a legitimate conflict (i.e., relationship or orientation confusion) and an OCD sufferer's torment is the felt need and anxiety experienced by the sufferer to gain an immediate, definite and conclusive resolution to the question.

Spikes about sexual orientation or the "rightness" of a relationship have a great deal in common. Many friends, family members and mental health professionals are all too often willing to entertain the noble effort of helping someone come to a decision related to whether or not to remain in a relationship or to pursue a homosexual lifestyle. Unfortunately, there is also ample opportunity for non-experts to provide a great deal of misguidance and misinformation for the OCD sufferer as to what makes someone gay or what variables make for a substantial relationship.

In one case, a mother of a patient suggested: "If you have this many questions, this close to the wedding, then there must be a big problem." The weight of this feedback eventually led to the termination of a wonderful relationship. In another case, an OCD sufferer with an obsession about being gay confessed in anguish to a school official that he was going through hell with the fear that he might be gay. His former high school coach sat him down and admitted that he had gone through the same torment in his own coming-out process. Needless to say, this misguided information set back progress a couple of months.

These two themes are rampant in many of our day-to-day lives. Therefore, it is understandable that without properly identifying that the origins of these questions are OCD related, it is easy for a friend, family member or even a therapist to believe they are being helpful when they offer advice. However, such "help and guidance" actually fuel the dilemma and distract from the genuine issue at hand.

OCD sufferers who spike about washing their hands until they "feel" clean or turning off a light switch until it "feels" complete make a critical error in information processing. They allow their experience to guide their choice as to whether they have completed the task. This is a mistake since the prevailing conceptualization of OCD today is that the fear center of the brain (amygdala) is impaired and considered responsible for the OCD sufferer's acting in such an unreasonable way. The sufferer remains completely aware of the irrational nature of his or her concerns.

People who do not experience OCD flip a switch once because they perceive and think that the light is off. They can also shut the water off because they can see their hands are no longer dirty. People who don't have OCD rely on perceptual information to complete these tasks. OCD sufferers continue to perform a task, either behavioral or mental, until they no longer feel unsettled or threatened by its incompleteness. It is currently believed that, since the part of the brain responsible for sending a signal of warning or danger is misfiring, the OCD sufferer is performing the escape or undoing response until she has "calmed down" her brain.

In the non-clinical population, decisions to remain in a relationship or awareness of one's sexual orientation are based on experience. In these circumstances, a person who doesn't have OCD will rely on emotional variables to guide his choices. Individuals who experience gay or relationship spikes are fully aware that there is a reasonable basis on which to make these types of decisions. Therefore, they tend to be very reluctant to commit to a relationship or behave in a homosexual manner without using emotional variables as a guide. Since the emotional portion of the brain is misfiring in OCD sufferers, it is essential that they abandon what would otherwise be a reasonable means of seeking guidance.

Maybe my pain is the natural outgrowth of having these real questions

Hey, isn't it natural that if you are considering

Relationship Substantiation PART I

breaking up with someone, that you would feel a great deal of pain and anguish?... Wouldn't anyone remaining in a relationship for all the wrong reasons feel this torment and guilt?... Isn't the coming out process a tremendously stressful time for anyone?... Maybe I don't have OCD?... Maybe I'm just here (i.e., therapy) as an excuse to avoid facing the fact that I am gay?

Just as we cannot ultimately prove that one cannot get AIDs from a door-knob, proof is also not available to those who ask these relationship/orientation questions in therapy. These seemingly reasonable questions mimic what one would go through in the real world when faced with these actual issues. Ultimately, there is no way to prove with absolute conviction that we are not making a grave mistake in treating these questions as an anxiety disorder, when what the patient really needs is relationship counseling. Since obtaining an answer to these unsolvable questions is impossible, this is a tricky situation for a therapist because she has to make a decision to treat the problem as OCD rather than as a relationship problem.

The Gay Spike

The majority of sufferers with this form of OCD evidence a completely traditional and non-conflicted childhood and adolescence in terms of sexual mores and identity. A lifetime of unwavering clarity related to their sexual orientation becomes spontaneously interrupted by the panic-stricken need to fully ascertain that they are definitely straight. A complicating norm of early and mid adolescence is the tendency of children of both sexes to engage in natural same sex exploration. This common tendency may explain the rampant nature of this spike theme occurring at this vulnerable developmental stage in life. At some point in mid-adolescence to early adulthood, the onset of this particular type of OCD obsession is triggered, usually with panic attacks and the associated idea that one may be gay. Generally, what follows is a never-ending expansion of an internal cognitive search for some conclusion to firmly establish the sufferer's sexual orientation.

Many sufferers take their endless search for an answer to the point of absolute desperation. In order to avoid being reminded that the painful question exists, persons will stop making eye contact with others of the same sex. In some rare cases persons have actually engaged in homosexual behavior to get a definitive answer. These

people think that if they find the encounter stimulating, then they are gay. On the other hand, if they are turned off by the encounter they feel they can rest assured they are straight.

Unfortunately, even desperate acts such as this provide nothing but more questions. Typically, the obsessive doubter will examine, with profound scrutiny, their arousal levels while viewing members of the opposite or same sex. It is within this desperate effort that deeper levels of ambiguity are delivered as a payback for the OCD sufferer's desperate search. The age-old adage, "the more we learn, the more questions we have" is certainly relevant here.

For the human sexual process to work effectively, the combined experience of both relaxation and arousal is a necessity. As it turns out, being anxious and aroused are mutually exclusive experiences. With this in mind, it becomes clear why any desperation related to an effort to become aroused has a paradoxical backlash effect of discomfort and non-sexual-responsiveness. "Gay spikers" often desperately attempt to use their ability to become sexually excited by persons of the opposite sex as a reassurance that they are completely straight. It is also sometimes the case that the more desperately one tries to not be aroused, the more one is likely to experience sensations in their groin, which could easily be mistaken for arousal. I often refer to this as a "groinal response", which is generally experienced equally by both male and female patients. The brain's desperate effort to search for any signal that might suggest the slightest hint of arousal furthers the likelihood that such an experience would be found. If a "gay spiker" were to see an attractive person of the same sex and check whether they are having a completely neutral sensation in their groin, there is a significant likelihood that they would feel a tingling and miss out on the opportunity to disqualify their homosexual inclination. This actual physical experience in their groin often validates in their own mind that they have definitive proof that this is not just a psychological condition but an actual manifestation of homosexuality. I am often confronted with the statement, "But Doc... if it were just an idea I'd be able to live with it... I actually feel something going on down there. So, I know it must be something more than just a question."

The desperation of the OC sufferer's effort in getting an answer becomes inadvertently the greatest hindrance to having any sense of their own sexual awareness and genuine experiences. As a sex therapist, I am profoundly aware that within the human condi-

tion it is impossible to know with absolute certainty one's own sexual identity. Many humans go through some period in their life where they question their sexual identity and sexual preferences. Although unsettling for most who go through this normal developmental process, it is nothing like the torture of the OC sufferer's desperate need to find an answer. Since this natural questioning process takes place during adolescence and since the onset of OCD is also associated with adolescence, the common nature of this particular OCD theme is more understandable.

Within the obsessive-compulsive condition, the mere question of not being certain of one's sexual identity becomes convincing proof that one's sexual identity is in question. In other words, within the obsessive-compulsive's mindset and cognitive framework, all persons on this planet have definite truths and absolute convictions about their sexual identity. Therefore, any possibility that one's sexual identity is not firmly established becomes a profound threat to reaching closure on this never-ending question.

It is very interesting that, for persons who have homosexual spikes, their general attitude toward homosexuality has nothing to do with the potential of this question to be threatening. Persons who are homophobic and terrified at the prospect of being gay as well as people who have a very raised consciousness about the acceptability of the homosexual lifestyle are equally as likely to develop this form of OCD. Therefore, attempting to raise one's consciousness of homosexuality as being an acceptable variant of a sexual lifestyle is not an effective treatment strategy. As is the case with all manifestations of OCD, the driving force for maintaining ritualizing involves: 1) the unsettling experience of merely "not knowing"; 2) the overwhelming sensation that one's life depends on the answer; and 3) the entrenched belief that getting the answer will solve the entire condition and bring about lasting relief.

The following case illustrates the fact that this form of OCD is about the desperate search, rather than the actual issue. A young man who had been completely accepting of his homosexuality for a number of years, came to see me. He had developed the spike and terror that he might be straight. He had been agonizing that all the work he had done in coming to accept his sexual orientation was wasted. He felt that if he could only prove that being intimidated by women was not the justification for his homosexual preference, then he would be able to go on with his natural and more familiar lifestyle. Ultimately, he chose to accept that he might prefer women. With the acceptance of this

Samuel Johnson

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his other more significant achievements was his eight-volume edition of the works of Shakespeare, which he published in 1765.



This plaque on the first story announces that this is where Samuel Johnson lived. Johnson, who was such an influential writer and thinker that the Age he lived in was named after him, achieved greatness while suffering with OCD.

Much of what we know of Johnson is thanks to James Boswell, who published his famous biography, "The Life of Samuel Johnson", in 1791. Boswell met Johnson in London in 1763 and the two became friends, traveling to northern Britain together. Dr. Johnson's OCD and Tourette's symptoms were well known to those acquainted with him and were well documented, particularly by Boswell. In one instance, Boswell noted one of Johnson's movement rituals:

He had another particularity,.... It appeared to me some superstitious habit, which he had contracted early, and from which he had never called upon his reason to disentangle him. This was his anxious care to go out or in at a door or passage by a certain number of steps from a certain point, or at least so as that either his right or left foot, (I am not certain which) should constantly make the first actual movement when he came close to the door or passage. I have, upon innumerable occasions, observed him suddenly stop, and then seem to count his steps with a deep earnestness, and when he had neglected or gone wrong in this sort of magical movement, I have seen him go back again, put himself in a proper posture to begin the ceremony, and having gone through it, break from his abstraction, walk briskly on, and join his companion.

Nearly everyone with OCD and/or Tourette's has had the experience of saying about his or her symptoms: "I know this sounds crazy, but I have to do it anyway." It must have been

especially maddening for a man as brilliant as Johnson to find himself trapped in a web of complex and illogical rituals and tics. In the eighteenth century, there were no diagnoses for these disorders, nor was there any form of real treatment. And, there was no understanding of these disorders on the part of the public. Such behaviors were commonly referred to as bad habits, fits, or even madness. Sufferers were either ridiculed, shunned or both. A Miss Frances Reynolds, the sister of the renowned English painter Sir Joshua Reynolds and a friend of Dr. Johnson's, wondered as to the cause of his strange behaviors:

What could have induced him to practice such extraordinary gestures? who can divine: his head, his hands and his feet often in motion at the same time. Many people have supposed that they were the natural effects of a nervous disorder, but had that been the case he would not have sat still when he chose, which he did, and so still indeed when sitting for his picture, as often to have been complimented with being a pattern for sitters, no slight proof of his complaisance or his good nature.

Obviously, Miss Reynolds could not be aware of the fact that those with tics and compulsions can, at times, successfully resist them, at least for some period of time. Her brother, Sir Joshua, had his own views on the origins of Johnson's behaviors, theorizing that:

It proceeded from a habit which he had indulged himself in, of accompanying his thoughts with certain untoward actions as if they were meant to reprobate some part of his past conduct. The great business of his life (he said) was to escape from himself, this disposition he considered as the disease of his mind, which nothing cured but company.

Those with OCD know that distraction can sometimes help to temporarily relieve obsessions. Fortunately for Johnson, he was a frequent guest in many social circles. It was perhaps Johnson's brilliant wit and creativity that won him the acceptance of so many of those around him in an age where behaviors such as he displayed could easily have been labeled as insanity. Johnson, himself, lived in lifelong fear of going mad.

On the day I chose to visit Dr. Johnson's home (now a museum), I went late in the afternoon, when it was not very crowded, and soon found myself alone there. Walking through the three stories of the small townhouse, I tried to imagine the difficulties he had had to overcome, unaided by such things as therapy, medication, or even a personal understanding of what was happening to him, in order to do even the most minor everyday tasks. I thought of my own patients and how much harder it can be for them to do the things most of us neurotypicals take for granted. As I stood in the attic where the famous dictionary was composed, I reflected upon how much greater were Johnson's achievements because of the numer-

ous obstacles he faced daily. Surrounded by pictures of Dr. Johnson, I could almost visualize this tortured, highly intelligent man vigorously hopping back-and-forth over the thresholds of the doors, repeatedly walking up and down the two flights of stairs while counting his steps, constantly touching the floor, and mumbling repetitive prayers to himself as he walked to his upstairs to begin work on some of the most brilliant writings of his day.

In addition to what may have been compulsive ritualizations, Johnson appears to have also suffered from obsessions involving guilt, religion, and responsibility. Comments about mental problems can be found among his writings; and it would appear that he was speaking from personal experience. In "Rasselas, Prince of Abyssinia," published in 1759, he made the following revealing observations:

Disorders of the intellect happen much more often than superficial observers will easily believe. Perhaps, if we speak with rigorous exactness, no human mind is in its right state. No man will be found in whose mind airy notions do not sometimes tyrannise, and force him to hope or fear beyond the limits of sober probability. It is not pronounced madness but when it [be]comes ungovernable, and apparently influences speech or action.



A stain glass window honoring Johnson the "Patron Saint" of OCD.

In this same work, he goes on to state:

No disease of the imagination is so difficult of cure, as that which is complicated with the dread of guilt: fancy and conscience that act interchangeably upon us, and so often shift their places, that the illusions of one are not distinguishable from the other. If fancy presents images not moral or religious, the mind drives them away when they give it pain, but when melancholick notions take the form of duty, they lay hold on the faculties without opposition, because we are afraid to exclude or banish them. For this reason, the superstitious are often melan-

(continued on page 13)

Bio-Behavioral Institute: In the Forefront of Treating OCD

The following is an interview with Fugen Neziroglu, Ph.D., of the Bio-Behavioral Institute in Great Neck, Long Island, in which she discusses the history of Dr. Yaryura-Tobias' and her pioneering work with OCD and the treatment available at the Institute.

NEWSLETTER: People with OCD have been coming to Bio-Behavioral Institute for treatment for a long time. Can you tell our readers the history of Dr. Yaryura-Tobias' and your involvement in treating OCD?

NEZIROGLU: In the early 1970's there were hardly any treatments for OCD. Dr. Yaryura-Tobias was commuting between the USA and Argentina monthly where they were using Anafranil, both oral and IV. He found it very helpful and asked Novartis (Ciba Geigy Pharmaceutical Co. at the time) if he could have access to the medication here. They said that he could use it if he was willing to do the first double blind placebo studies. He agreed and recruited me to help him. We tried Anafranil on patients with OCD and patients with Schizophrenia and OCD and published two papers in 1975 and 1976 indicating its efficacy over placebo. In 1977, Dr. Yaryura-Tobias then published an article on the serotonergic hypothesis of OCD. He first hypothesized that Anafranil was the only medication that was effective for OCD because of its serotonin specificity. We then proceeded to measure platelet serotonin in patients with OCD and in "normal controls." That is how the concept of serotonin specific reuptake inhibitors (SSRI) evolved.

We were using Anafranil in our practice for 10 years before it was marketed in the United States. In the interim, the patent for Anafranil was running out and Ciba Geigy no longer wanted to proceed with its studies. But we begged them to continue to supply us with Anafranil and they set up a humanitarian protocol that allowed patients who had participated in our studies to continue on it. That was a great help, but it still left a situation where the majority of the people we were treating weren't eligible for the Anafranil because they had not been in the initial studies.

We tried stretching the humanitarian protocol the best we could and then resorted to getting the drug from Canada and Mexico. Our new marketing adventure did not go over too well with the FDA and some of our patients began to actually go to Canada and Mexico to get the drug for themselves and for some of our

other patients. We knew we could not rely on this method for too long and we went back to Ciba Geigy. We tried to convince the company that there were many more patients than they realized. At the time the estimated prevalence was 0.5% and



Fugen Neziroglu, Ph.D.
Clinical Director at Bio-Behavioral Institute.



Dr. Jose Yaryura-Tobias Bio-Behavioral's Medical Director, did the first double blind studies on Anafranil on patients with OCD in the United States.

only two pages was devoted to it in the classical texts of psychiatry. We tried to tell them that the correct questions were not being asked and that OCD patients were very embarrassed and secretive about their symptoms. We felt that the onus was on us as mental health professionals to ask the right questions to get patients to start talking about their OCD.

At the same time we started our behavior therapy program and implemented weekly and intensive outpatient treatment. In addition, in 1979 we incorporated the Obsessive Compulsive Society composed of patients as officers and ourselves as assistants. We met at a local library. Working with this group of patients, we were able to convince Ciba Geigy whose patent on Anafranil had fortunately been extended to continue the OCD studies.

At the time Isaac Marks, M.D., in England and Edna Foa, Ph.D., in Pennsylvania were the only behaviorists treating OCD. We began to incorporate a very similar program here in Great Neck, New York. In 1983, we added the inpatient intensive program for both our local and out-of-state patients.

NEWSLETTER: Can you describe the different types and levels of OCD treatment available at Bio-Behavioral Institute?

NEZIROGLU: We learned long ago that each patient's need was different and that different levels of treatment were needed for different reasons. We offer inpatient as well as outpatient psychological services varying from weekly 45-minute sessions to daily 3-hour sessions. Our intensive

treatment may be from three to six times a week for the duration of one month to several months. During the consult visit, we determine whether a patient needs only behavior and cognitive therapy or a combination of medication and behavior therapy and how often the patient needs to be seen. Sometimes other mental health professionals refer patients to Bio-Behavioral to add behavior therapy to the existing medication regimen or to add behavior therapy to supportive psychotherapy. When medications are involved, we almost always add behavior therapy because we know the long-term prognosis is much better. We also offer therapy groups for hoarding and cognitive therapy as well as a long-standing monthly OCD support group.

NEWSLETTER: What treatment modalities are used at Bio-Behavioral for treating OCD? Does your program emphasize psychopharmacology or cognitive behavior therapy or a combination? Are there other treatments used at the Institute?

NEZIROGLU: We offer psychopharmacological and psychological services and believe in an integrated approach to treatment, stressing a combination of both modalities. By psychological services we mean behavior and cognitive therapy, specifically, exposure and response prevention. We do use other behavioral approaches for concomitant problems, such as, assertiveness training, exposure treatment for those with an abuse history, dialectical behavior therapy for borderline personality disorders, cognitive therapy for depression, anger control and a combination of treatments for self-mutilation. Because we treat OCD Spectrum Disorders, such as, body dysmorphic disorder, trichotillomania, Gilles de la Tourette Syndrome and hypochondriasis, we emphasize different treatment modalities more appropriate for those disorders, i.e, habit reversal for trichotillomania or Tourette's Syndrome. For some of the Spectrum Disorders, medications are more appropriate than for others. We have ongoing research on the Spectrum Disorders and are now more specific in terms of what treatments to use for what disorders.

NEWSLETTER: Do you have a specific Intensive Treatment Program at the Institute? Could you describe it for our readers?

NEZIROGLU: Patients initially meet with either a psychologist or psychiatrist for a consultation appointment. Then our clini-

Research Digest

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

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

Acute onset of obsessive-compulsive disorder in males following childbirth
Psychosomatics, 42:429-431, 2001, J. Abramowitz, K. Moore, C. Carmin et al.

In women, pregnancy and the postpartum period have been associated with the onset of OCD and the worsening of pre-existing OCD. Experts consider two causes for this: effects of hormones and effects of stresses involved with pregnancy and caring for a new infant. Little is written on the relationship between fathers and pregnancy or childbirth. This paper presents four case reports of men with onset of OCD coinciding with a spouse's pregnancy or delivery. The rapid onset of OCD and the content of obsessions and compulsions (harming the infant) were similar to those reported in studies of postpartum OCD in women.

Insight and treatment outcome in obsessive-compulsive disorder
Comprehensive Psychiatry, 42:494-497, 2001, J.L. Eisen, S.A. Rasmussen, K.A. Phillips et al.

Patient insight into OCD ranges from good, in which patients clearly recognize the senselessness and excessiveness of their obsessions, to poor, in which patients are convinced their obsessions are realistic and reasonable. Researchers studied whether patient insight improves when OCD symptoms decrease and if the degree of initial insight predicted response to sertraline (Zoloft). Insight did improve as the symptoms of OCD decreased, but the degree of insight did not predict response to sertraline. Patients with poor insight were just as likely to respond to sertraline as patients with good insight. There have been recent reports that poor insight contributes to poor response to behavior therapy. Authors suggest that insight may be more important as a response predictor with behavior therapy than with medication.

Clinical predictors of drug response in obsessive-compulsive disorder
Journal of Clinical Psychopharmacology, 21:488-492, 2001, S. Erzegovesi, M.C. Cavallini, P. Cavedini et al.

Selective serotonin reuptake inhibitors (SSRIs) are the first-line medication treatment of OCD, but 40%-60% of patients do not respond to treatment with SSRIs. The aim of this study was to evaluate factors that could predict an individual's response to SSRI treatment. Of 159 patients with OCD taking fluvoxamine (Luvox), clomipramine (Anafranil), citalopram (Celexa) or paroxetine (Paxil) for 12 weeks, 57% responded and 43% did not respond to medication. Responders had significantly more family members with OCD, onset of OCD at a later age and better insight into their illness. Based on these findings, it is important to collect information on family history and evaluate patient insight in order to better predict drug response.

It is not unusual to find disagreement in study results: here poor insight predicted poor response where that was not true in the Eisen et al. study (see previous abstract). Differences in the ways study populations, medication, investigators and insight were assessed may explain these discrepancies. (JHG)

Long-term sertraline treatment of children and adolescents with obsessive-compulsive disorder
Journal of the American Academy of Child and Adolescent Psychiatry, 40:1175-1181, 2001, E.H. Cook, K.D. Wagner, J.S. March et al.

This study investigates the long-term (one year) effectiveness and safety of sertraline (Zoloft) treatment of children and adolescents with OCD. After completing a 12-week double-blind study with sertraline, 137 children and adolescents continued sertraline treatment in this one-year extension study. Sixty-five patients completed the study with an average sertraline dose of 157.3 mg/day at week 52. Sertraline was well tolerated and there were no discontinuations due to changes in vital signs, laboratory values, or electrocardiograms. Significantly not only did these children and adolescents maintain their treatment response for the 52 weeks, but the response had increased at the end of the year's treatment. The average Child Yale-Brown Obsessive Compulsive Scale (CY-BOCS)

improved from an initial 22.8 before treatment to 17.0 after the initial 12 week study to 10.8 at the end of the 52 weeks. Some patients who were nonresponders after 12 weeks of sertraline treatment in the acute study became responders with continued treatment. This suggests that a medication trial for longer than 12 weeks may benefit some children and adolescents who initially show little response to medications. The continued improvement in symptoms with long term treatment also supports the current recommendation of continuing medications for 9 to 18 months.

Whether the large further improvement that occurred between weeks 12 and 52 is attributable to continued medication or to professional or naturalistic cognitive behavior therapy that was allowed but not provided is unknown. (JHG)

Olanzapine augmentation for trichotillomania
American Journal of Psychiatry, 158:1929-1930, 2001, A.K. Ashton

Olanzapine (Zyprexa) was added to citalopram (Celexa) treatment in four women with treatment resistant trichotillomania. Three of the four women had a clear improvement in their trichotillomania and the benefit persisted over several months. The olanzapine doses ranged from 1.25 mg/day to 15 mg/day with the one nonresponding individual taking the smallest dose, 1.25 mg/day.

Cognitive-behavioral family treatment of childhood obsessive-compulsive disorder: preliminary findings
American Journal of Psychotherapy, 55:372-387, 2001, T.L. Waters, P.M. Barrett and J.S. March

Researchers believed a family approach would be advantageous because of high levels of family involvement (assisting with rituals and giving reassurance), poor treatment outcome having been associated with family anger and criticism, and higher prevalence of OCD in family members. In this 14-week pilot study of family-based cognitive-behavioral treatment, positive improvement in OCD symptoms occurred in six of the seven children participating. Even including the child who did not improve significantly, the average reduction in the Child Yale-Brown Obsessive Compulsive Scale score was 13.1 which was highly significant ($p < .001$, meaning the likeli-

Research Digest

hood of this result occurring by chance is less than 1 in 1,000). Additionally, the amount of family accommodation (family involvement in the disorder) significantly decreased. Treatment consisted of two components: individual cognitive-behavioral therapy and parent-skills training. The primary aims were to create an "expert team with the parents, child, and therapist;" to provide education on OCD and its treatment; to reduce parental involvement in the child's symptoms; to encourage family support of home-based exposure and ritual prevention; and to increase problem-solving skills.

Once again, we see large improvements with cognitive-behavior therapy (CBT) in children suffering OCD. Remembering that the average improvement found in the studies of children and adolescents treated with clomipramine (Anafranil), fluvoxamine (Luvox) and sertraline (Zoloft) - that led to FDA approvals for treating OCD in children and adolescents - was 7.1, this study provides further evidence that CBT is at least as effective as medications. The main problem with CBT remains its lack of availability. (JHG)

Family involvement in the behavioral treatment of obsessive-compulsive disorder: A preliminary investigation Behavior Therapy. 32:803-820, 2001, M.S. Grunes, F. Neziroglu and D. McKay

This is another recent study suggesting an advantage to family members participating in the behavioral therapy program of OCD patients. Two groups of OCD patients (14 in each group) received exposure and ritual prevention. In one group only individual behavior therapy was conducted. In the other group, in addition to the individual's behavior therapy, a family member participated in an 8-week family-intervention group. The patients whose family member was involved in the treatment program had a greater reduction in OCD symptoms than patients without family member involvement. Additionally, patients had a greater reduction in depressive symptoms and family members had a greater reduction in expressed emotion. OCD has significant adverse effects on families and marital relationships. By engaging family members in the treatment there can be improvement in family functioning and, as this report indicates, an additional improvement in the patient's OCD.

Video Review: The Surface

According to Michael Jenike, "The Surface" is awesome!"

By John Metherell

A problem that many OCD sufferers wrestle with is how to get other people - family,



John Metherell, the reviewer

friends, colleagues - to understand what they're going through. Why are they compelled to perform their rituals? What's driving their compulsions? Why don't they

just stop? In a 14-minute video, Adam Bernard answers some of those questions. Adam wrote, shot, directed, edited and produced this insight into what it's like to deal with an OCD monster that is constantly sowing doubts in the mind. Did I complete my rituals? What are the consequences if I didn't? What can I do to put things right? He does this through an interesting dramatic technique. The piece opens with the teenage hero obsessively practicing basketball hoops. It's clear he's been doing this for a while today and perhaps every day. A wide variety of camera shots match the variety of attempts to get the ball through the hoop. When he thinks he's finished, he's confronted by another character who tells him he hasn't completed the ritual correctly and



Matt Bullard playing "OCD" tries to intimidate the hero one last time.

sive it means a return to the hoop.

It becomes clear through some expressive dialogue that the harbinger of doom is the hoop-player's alter ego. He's a manifestation of the voice inside an OCD sufferer's head

threatens him with the ultimate sanction: an early death. This would be enough to make anyone think twice about going into the house. For an obsessive-compul-

that urges them to throw more hoops, to be concerned about catching a fatal disease, to fear a collision with a pedestrian while driving. Adam is served well by his two main actors who provide convincing performances as the pleasant young man, "Brian", and his evil twin. As the film progresses, it becomes clear that nobody else can see the "OCD" monster. Luckily, when the antagonist is becoming extremely frustrated a friend enters the hero's life and offers to help banish the demon.



"Brian" tries to bar the door against "OCD's" continuing demands for him to keep performing his rituals.

The oblique approach to the subject works well. It's not clear at first what's happening. When viewers begin to understand what's going on and say, "Now I get it," OCD sufferers can reply, "Now you can begin to understand what I'm going through." Adam Bernard shows talent in video production and "The Surface," an insider's look at OCD, deserves wide distribution.



Mike Hayhurst playing "Brian" tries to persuade "OCD" that he doesn't need to perform any more rituals.

To order copies of "The Surface" on VHS format, you can send a check or money for \$15.00 (which includes shipping and handling) to: ANB Productions, LLC, P.O. Box 1288, Farmington, CT, 06034-1288. To learn more about "The Surface," please visit www.anbproductions.com or contact the producer, Adam Bernard, at anbproductions@hotmail.com.

John Metherell produced a documentary on OCD for The Discovery Channel, "Extreme Conditions: OCD," which won a Cine Golden Eagle, one of the most prestigious awards given to documentaries. He also teaches production classes at American University in Washington, DC, and Towson University in Maryland.

From the Foundation

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whether to pay out of pocket to protect my privacy or to claim reimbursement thereby revealing my condition and possibly endangering my job.

I was a pretty lucky individual. And continued to be, even when the drug trials ended and there were no more free refills. By this time, my employer, a rather large insurance/healthcare company, had "encouraged" most of its employees to switch from its indemnity plans to its HMO. The HMO plan with its \$5.00 prescription co-pays allowed me to continue to escape the financial drain that was caused by the disparity in coverage between physical illnesses and mental illness. Even when the co-pay went to \$10.00 I was not concerned. I could afford that without any sacrifice.

But I was about to become very concerned. Although at the time, I thought the problems were administrative snafus, not a wholesale policy change on the part of my HMO. When I went to pick up my prescription, the pharmacist said he didn't fill it because it wasn't covered under my plan. I sputtered, fumed and asked for the phone. I called the customer service number and after a blast of country and western music got to talk with a representative who looked up my file and assured the pharmacist and me that my medication was covered.

This scenario repeated itself for several months until I got smart enough to ask the pharmacist to call the plan when I brought the script in. This worked for a while. I may have been a bit inconvenienced, but the parity issue wasn't my personal problem yet.

Then, one bright summer morning the pharmacist handed me my prescription and rang up a charge of \$329. "There's got to be a mistake. Call my plan." He did. No mistake. My medication was no longer covered. It had been replaced by a generic. I had a choice: change my medication based on carefully considered cost-saving measures dreamed up by ambitious new middle managers recently recruited from the credit card collection unit at a large New York bank (sometimes the information you have because you're an insider is more distressing than ignorance) or let the pharmacist ring up \$329 on my Am Ex. Faced with a financial crisis like this promised to be, I knew I'd need my original medication.

I reacted in character. In a growing state of fury and panic, I surrendered the card and, aiming my car in the general direction of my office, I started planning mayhem. Luckily, my survival instincts clicked in. What I did do was called the head of the pharmacy unit whose office window was facing mine and down a floor. I explained my problem, instructed him to look up and see for himself what real fury looked like and then suggested that if he thought he might need the protection of the legal department in the near

future, he'd better reevaluate his new "generic exclusion" in light of the actual policy language and the fact that no one knew what I was capable of if deprived of my medication. Sometimes, the general public's ignorance of the nature of OCD can be used to our advantage.

Suffice it to say, I got my medication and a reimbursement. I was told it was because my doctor with prompting had called and informed the plan that "in his medical opinion" the generic would not be a suitable substitute for me. I did not stop to worry at that point about the other people whose medication was being changed by the credit card guys. I had mine and for only the \$10 co-pay.

But, this was the beginning of the end. Since last March, there has been a co-pay creep that was not heralded in bold print in the plan booklet. First, the co-pay was \$32.07, then \$37.75, then and \$75.03. For the last three refills, it's been \$89.70. According to the paperwork on the drug bag, the \$89.70 is one-third of the total price of the medication. I wrote a letter to the head of the pharmacy plan. He did not reply. Nor did anyone on his staff. I'm going to write another letter. This one with a "CC" to the Insurance Department. Hopefully, that will open a dialogue.

And, now that I've learned the hard way that discriminatory health care coverage is a personal problem for everyone affected by OCD, I'm also going to ask everyone who is reading this to think about the big picture. Last year, we wrote letters from the Foundation to key legislators urging the passage of the health care parity bill. We put up sample letters on the website and encouraged visitors to download them and send them to their representatives. At conferences and meeting with other mental health advocacy groups we discussed the importance of passing the parity bill. Everybody thought it was going to happen. We were so close. But it didn't happen. Somehow after passing in the Senate, it slipped into oblivion. We can't allow it to stay there. We have to rescue it and get it passed for our own sakes. So what can we do? Monitor what's happening on the parity bill. Write letters to newspapers. Discuss it in chat rooms and with acquaintances. Find out where your representatives stand on parity. Call and write them. Persuade them that passing a parity bill is important to the continuation of their political career. Talk at public meetings and forums. The only way to assure that each one of us can afford the medication we need is to make sure that all of us can. I'm taking this parity thing personally from now on. I hope you do too.

Ciao!



Patricia Perkins-Doyle

Jenike Reviews Schwartz

(continued from page 3)

OCD symptoms at face value. The aim of practicing these exercises is to "see the reality of what is going on." To really "know" that: "It is not me, it is just OCD." This feeling is just OCD. This is, according to Dr. Schwartz, "Progressive Mindfulness."

When you "Revalue," under Dr. Schwartz' method, you strengthen the impartial spectator. Eventually, you can get into an automatic refocusing mode. You recognize OCD symptoms almost automatically and move on. You are NOT just saying to yourself that it is only my OCD. It is observing and feeling your own sense of discomfort as the OCD. The goal of "Progressive Mindfulness" is to experience the bad thoughts and urges as OCD, not as legitimate or real thoughts, and then you automatically move forward.

Dr. Schwartz' closing words are: "Keep working, keep your spirits up, Be mindful, may you be well!" My gold standard for any therapy is "Does it help patients get better?" Since the concepts in this CD are the same as those outlined in "Brain Lock," they will be useful to many patients. I have had many tell me that these four steps have helped them move beyond their OCD.

"Mindfulness" and nurturing of the "Impartial Spectator" are concepts that make sense to many people. It has been my experience that patients with the more severe forms of OCD are not able to effectively utilize these concepts. Rigorous approaches with more external motivators and coaches are required. I think it is important that Dr. Schwartz clearly acknowledge that these steps do not work for all (e.g., it won't work in those situations where the sufferer cannot "Relabel") and carefully clarifies early on in the CD that for severe cases the "Four Steps" can't be taken until the patient has been stabilized with medication and classical CBT, so that patients are not unfairly accused of being unmotivated to get better. I have seen family members get very angry when patients have not traveled smoothly through the "Four Steps."

I promised myself that I will never again think about how hard it is to hit a basketball shot. I'll bet I could even impair Michael Jordan, the other Dr. J, if I got him thinking. Unfortunately, with OCD it will take a more active approach to recover, and this CD will give OCD patients another effective weapon to use to battle this disorder.

A copy of Dr. Schwartz' CD, "The Four Steps: New Developments on Progressive Mindfulness," can be ordered by contacting Daisy Sanchez at the OCF, the number is 203-315-2190, ext.13.

The cost is \$9.98 plus \$4.50 for shipping and handling.

From the President

(continued from page 1)

exhibition booth emblazoned with the Foundation's goal: "Effective Treatment for Everyone with OCD."

This meeting is an excellent networking opportunity for the Foundation and other similar non-for-profits, pharmaceutical companies and treatment providers.

Last spring we also organized an Education Task Force. Its charge is to review the programs currently in place which educate teachers about OCD in the classroom, and to develop improvements and a better delivery system for delivering our information to schools. The Task Force made up of volunteers from our membership includes: Gail Adams, St. Charles, IL; Bernie and Edna Bahr, St. Louis, MO; Ron Bernard, Farmington, CT; Anne Coulture, Evanston, IL; Andy Emmerman, Winnetka, IL; Randi Frankel, Glenview, IL; Joy Kant, Waban, MA; Paula Lancer, Hewlett, NY; Linda Marty, Arnold, MO; Ed Matisik, Washington, DC; John Metterell, Silver Spring, MD; Tamra Wulff, Omaha, NE and Karen Yuan, Colorado Springs, CO. After conference calling during the spring and early summer, we had our first face-to-face meeting at the 8th Annual Conference in Denver.

The Foundation's 8th Annual Conference in July offered 58 seminars, workshops and support groups. We even had a film festival featuring videos by young screenwriters with OCD and saw the premier of the Discovery Channel special "Extreme Conditions: OCD." There was a Town Meeting devoted to the a paramount concern, "Getting a Loved One into Treatment." The kids enjoyed a pool party with Marc Summers, host of "Double Dare" and "History IQ." The Foundation's Board convened at the Conference and enthusiastically approved the creation of an OCF Genetics Consortium.



Casey Merritt (left), Teresa Early (center) and Denise Payne (right) run the registration desk at the First OCD Benefit Golf Tournament.

Throughout the fall, friends of the Foundation sponsored a variety of fundraisers to support our projects. Leah Davis of Cumberland, MD, with her friends and neighbors organized with professional aplomb the First Obsessive Compulsive Disorder Benefit Golf Tournament at the Rocky Gap Lodge and Golf Resort. Despite torrential rains, the tournament was a success. The money raised from this Tournament was donated to support the Foundation's programs.

In October, Nancy and Robert Guenther of Evanston, IL, held a fundraiser with desert and a presentation, which has raised more than \$8,000 for the OCD Genetics Consortium with checks continuing to come in. Dr. David Pauls of Harvard, who is heading the Consortium, was the guest speaker.



Daisy Sanchez, Hilary Macko, and volunteer Carole Ringuette at the Hoarders' Tag Sale this fall.

In late October, the OCD staff and local Connecticut volunteers put on an outdoor "Harvest Festival and Hoarders Tag Sale." It was a great day, which not only raised money for the Education Task force but also raised awareness about OCD.

On December 5, "Scoot," host of "The Buzz," a radio talk show on AM 620 in Portland, OR, raised \$320 for the Foundation by participating in a "Scratch Off for Charity." Local celebrities, representing the charity of their choice, had five minutes to scratch as many Oregon Lottery tickets as they could.



The Monti family, Karyn, Elyse and Henry, Rhode Island Congressman Jim Langevin at his Holiday Gathering where over \$1,400 was raised for the OCFoundation.

Henry Monti's, teenage daughter, Elyse, has conquered her OCD. But the Monti family of East Greenwich, RI, was concerned about others who suffer from OCD. Henry, an attorney, went to his friend, US Congressman Jim Langevin and asked him include the OCF as one of the charities for which he raised funds at his annual Holiday Gathering. He did and we are still getting checks in the mail from supporters of the Congressman, who, by the way, is a tremendous champion in Congress for the disabled.

Contributions for the End-of-the-Year Campaign and the Research Fund Drive are also still coming in. We truly appreciate everyone's generosity, which is doubly commendable because of the down turn in the economy and the tragedy of September 11.



Jeannette Cole, posing with friend at the Tag Sale.

Now we focus our attention on a new year. We have set some pretty aggressive goals for 2002 and our staff and Board are enthusiastically moving forward.

We have invited a select group of scientists to join the OCD Genetics Consortium and have already begun to receive acceptances. Our present plan is to have the initial meeting of the Consortium at our 9th Annual Conference in Philadelphia.

The 2002 OCF Research Awards program is well underway. The proposals are currently under review by members of our Review Committee. We expect to announce the winners and their projects in March.

The deadline for presentation proposals for the 9th Annual Conference was January 15. The planning committee is now reviewing them and putting together a great program for you. Dr. Pierre Blier of the University of Florida will be our Keynote Speaker.

Presently, the committee is putting together "centerpiece" symposia on Obsessional Thinking and Body Dysmorphic Disorder. We also hope to have another film festival featuring the works of our own members.

Other plans on the drawing board are: an Annual Review of research reports and articles on OCD and the Spectrum Disorders, which would be a collaboration between the OCF and the Obsessive Compulsive Information Center. We are also working on developing a formal program on OCD for volunteers to put on in their schools and a series of articles on the Americans with Disabilities Act.



The Monti family and friends at Congressman Langevin Holiday Party at the elegant Aldrich Mansion in Warwick, Rhode Island.

I also am looking forward to including more members in the Foundation's activities. We need all the help we can get. If you have an idea you'd like to share or a skill you can donate, send e-mail to info@ocfoundation.org. I'm looking forward to a productive year, one in which we work together to strengthen the Foundation and expand our services.

Best regards,
Janet Emmerman
President, OCF Board of Directors

I Think It Moved PART I

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possibility, he went on engaging in his own healthy and natural exclusively homosexual relationships.

Escape and Avoidance

The predominant rituals of people with this type of OCD involve a tremendous amount of avoidance of any stimuli that might provoke the question. They stop looking at others of the same sex for fear that they might develop a reaction of interest or stimulation which might become further evidence of being gay or of not-knowing for sure. There is also a tremendous amount of avoidance involved in dating or seeking out sexual contact from persons of the opposite sex for fear that the absence of an anticipated arousal response will become conclusive evidence that the threat might be real. Masturbation is also something that becomes threatening and, therefore, is often a discontinued natural practice.

Internally, the rituals involve a never-ending all-consuming thought task to conclusively derive an answer as to one's sexual identity. Being on a date, walking down the street, or engaging in masturbation are wonderful spike generators.

OCD sufferers with these obsessions will typically do a tremendous amount of research about what makes a person gay. There tends to be an inverse and paradoxical relationship between the amount of information one finds out about the determinants of homosexuality and the amount of doubt, ambiguity, and torture associated with ultimately not "knowing for sure." In plain English, this means that the more information garnered oneself from the Internet about "how to know if you are gay," the less convinced the "gay spiker" becomes of being straight. As more information is uncovered about the origins of homosexuality, the OCD sufferer feels farther than ever from a conclusive answer.

As a sex therapist, I could provide a detailed outline of what variables are explored in the psychological determination of whether a person is gay. This information would do nothing to help the OCD sufferer to come to a conclusion. It is strongly recommended that little to no time be spent engaging in any discussion regarding the person's actual sexual orientation. If and when this discussion takes place, it is recommended that it be made very clear that this information gathering is not going to end the obsessive ruminating.

Treatment Considerations

Therapeutically speaking, this is an extremely treatable form of OCD. However, most people dread the treatment because the therapeutic goal is the exact opposite of the person's

emotional agenda. Obviously, persons come in for treatment for this form of OCD desperately looking for the psychologist to give them the conclusive answer to their sexual orientation. For those mental health professionals who are not trained or sophisticated in the treatment of OCD, a tremendous amount of time and effort is wasted on endless attempts at reassuring the client that they are indeed not gay. On occasion, mental health professionals have even suggested giving a homosexual experience a try to help get the truth out. For those who are adept at identifying that these people are dealing not with a sexual orientation crisis, but with an anxiety disorder, the focus is not on deriving an answer about the person's sexual orientation, but on helping a person accept the unanswerable nature of this question.

Giving one's brain permission to be creative is a good start for treatment of this kind of obsession. The goal is to have the sufferer understand first that these thoughts are manifestations of OCD and because of that will never be "resolved." The best therapeutic answer that comes at the end of treatment is the ultimate acceptance of the uncertainty related to the genuineness of their sexual orientation. "I may be gay" is then the best response to the question.

When a client with this obsession responds to my question, "Are you gay?" with "I'm not sure," "I don't know," or even "Let's go to The Village and find out," I feel pretty confident that he or she is beating the OCD. One need not be sure of one's sexual orientation in order to pursue members of the opposite sex. One need not be sure of one's sexual orientation to ask a person out on a date. It is critical that, while following through on these potential interests, that one not search within one's self for the absolute answer on one's sexual identity. In other words, if at the end of treatment you find yourself having a "great time" on the fourth date, do not use this information to be convinced that this means you're not gay and that this was OCD all along.

In treating this manifestation of OCD, the clinical course initially involves the client establishing a hierarchy. The items on this list should pertain to stimuli which provoke the potential reaction or questions about one's sexual identity. A very common first step would be to have a person walk down the street and rate on a scale from one to ten the attractiveness of persons of the same sex. One might even expose one's self to a provocative website and see if he can view it without obsessing over his orientation.

Is my pain a result of having OCD or discovering I'm gay?

Ultimately, in the course of treatment, the most threatening question a person with OCD has to deal with is, "Do I indeed have OCD or is the distress and panic I am experiencing a manifestation of what one would

naturally go through when one is 'coming out' as a homosexual?" In the hierarchy, this ultimately becomes the last barrier to clinical success. Since OCD's main motivator is anxiety-based, there is generally very little confusion on the part of the experienced clinician as to whether the presenting problem is just another spike or a coming-out crisis. The terror experienced at having to get the answer to the overriding question "Am I gay?" is a clear signal that homosexuality is not the issue.

The old backdoor spike

A common phenomenon associated with therapeutic success is an experience I refer to as the "backdoor spike." A backdoor spike is the threat which emanates out of no longer experiencing anxiety in association with the ambiguous question. For most OCD sufferers, getting anxious is a bit of a reassurance that something is amiss. "How do I know that I have OCD and I'm not really gay? Because the mere question makes me so anxious." Therefore, when someone reaches his therapeutic goals and no longer experiences anxiety in association with the spike, the threat that the question might be real, without producing anxiety, becomes a whole new spike. In other words, patients then become anxious because they are no longer anxious.

TO BE CONTINUED. In the Spring 2002, Dr. Phillipson will continue his discussion of obsessions about relationships. The focus of that discussion will be the obsession about picking the right partner.

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Samuel Johnson

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choly, and the melancholy are always superstitious.

He may have also indulged in compulsive prayer rituals to deal with his religiously scrupulous or superstitious thoughts. Boswell wrote of him: "Talking to himself was, indeed one of his singularities ever since I knew him. I was certain that he was frequently uttering pious ejaculations; for fragments of the Lord's Prayer have been distinctly overheard."

Johnson's numerous tics were also quite well known to his acquaintances, not to mention anyone who happened across him in public. Boswell provides a description of some of Johnson's vocal tics:

In the intervals of articulating he made various sounds with his mouth, sometimes as if ruminating, or what is called chewing the cud, sometimes giving a half whistle, sometimes making his tongue play backwards from the roof of his mouth, as if clucking like a hen, and sometimes protruding it against his upper gums in front, as if pronouncing under his breath too, too: all this accompanied sometimes with a thoughtful look, but more frequently with a smile.

Miss Frances Reynolds also took note of some of his motor tics, reporting that:

His mouth is continually opening and shutting, as if he were chewing something; he has a singular method of twirling his fingers, and twisting his hands; his vast body is in constant agitation, see-sawing backwards and forwards; his feet never a moment quiet; and his whole great person looked often as if it were going to roll itself, quite voluntarily, from his chair to the floor.

Describing a walk she had taken with him one day, Miss Reynolds notes:

I well remember that they (his gestures) were so extraordinary, that men, women and children gathered around him laughing and they nearly dispersed when he pulled out of his pocket Grotius' De Veritate Religionis, over which he see-sawed at such a violent rate as to excite the curiosity of some people at a distance to come and see what was the matter with him.

One further observation by Miss Reynolds was that:

The manoeuvre that used the most particularly to engage the attention of the company was his stretching out his arm with a full cup of tea in his hand, in every direction, often to the great annoyance of the person who sat next to him, indeed to the imminent danger of their cloaths

sometimes he would twist himself round with his face close to the back of his chair, and finish his cup of tea, breathing very hard, as if making a laborious effort to accomplish it. ...

Johnson's numerous witty quotes fill whole sections of books and he appears to never have been at a loss for words. One anecdote that Boswell recounts indicates Johnson's ability to cope with the remarks and questions of others concerning his odd behaviors in public:

I am happy, however, to mention a pleasing instance of his enduring with great gentleness to hear one of his most striking peculiarities pointed out a very young girl, struck by his extraordinary motions said to him, "Pray Dr. Johnson, why do you make such strange gestures?" "From bad habit," he replied. "Do you, my dear, take care to guard against bad habits."

In actuality, Johnson rarely spoke of his compulsive and ticcing behaviors, but was apparently able to speak up in his own defense. When, at a dinner, he accidentally knocked another guest's shoe off her foot with one of his hand movements, he responded to the laughter that inevitably followed, saying, "I know not that I have justly incurred your rebuke. The motion was involuntary, and the action not intentionally rude."

From my nearly twenty years experience as a clinician, I can only imagine what this man endured, both in public and in private. Those with OCD and Tourette's have made great strides in the last twenty years in terms of gaining public understanding and finding more effective treatments. It is saddening to look back on those people in the past who had no choice but to face each painful day with their overwhelming and seemingly mysterious symptoms. No doubt Dr. Johnson was having one of those symptom-filled days when he came up with the quote that opened this article. It is uplifting and inspiring, however, to also look back on what some of those sufferers were able to accomplish in spite of their problems. They serve as great examples to all who suffer. Perhaps there really are patron saints of OCD, and if so, Dr. Samuel Johnson may have been one of them. I will leave you with one last quote of Dr. Johnson's, perhaps a thought that helped him to sustain himself: "Great works are performed not by strength, but by perseverance."

Dr. Fred Penzel is a licensed psychologist who has specialized in the treatment of OCD and related disorders over the last twenty years. He sits on the Science Advisory Board of the Foundation, and is a frequent contributor to the OCD NEWSLETTER. He is the author of the self-help book, "Obsessive-Compulsive Disorders: A Complete Guide To Getting Well And Staying Well."

You can contact him at: penzel@attglobal.net.

Do Mice Have OCD?

*By David Pauls, Ph.D. Harvard Medical School,
Chairman, OCD Genetics Consortium*

Researchers at the University of Utah have identified a gene that appears to be related to grooming behavior in mice. Drs. Joy M. Greer and Mario Capecchi reported their findings in the journal *Neuron*. Briefly, mutations in a gene (Hoxb8) that produces a protein that controls the activities of other genes cause mice that carry this mutation to groom themselves excessively, sometimes creating bald spots and skin lesions on various parts of their body.

The researchers suggest that this may be a good animal model for trichotillomania and some kinds of OCD that involve excessive cleaning. This is potentially a very important finding. However, it remains to be seen whether this same gene causes these behaviors in humans.

Clearly this gene needs to be examined in individuals with OCD and related conditions like trichotillomania. There have been a number of reports in the scientific literature of these kinds of behaviors in dogs, birds and other animals, but to date, none of them have been shown to be definitively related to the same kinds of behaviors in people. Nevertheless, all of these animal models may prove very useful in the future when genes for OCD and related behaviors have been identified in humans.

As many of you may know, the Obsessive Compulsive Foundation recently made a commitment to support genetic research on OCD by setting up an OCD Genetics Consortium. There will be a meeting of OCD researchers from around the world who have expressed an interest in being part of this Consortium in conjunction with the 9th Annual OCD Foundation Conference in Philadelphia next summer. It is hoped that from this meeting a Consortium of researchers will emerge that will work together to unravel the genetics of OCD.

Genetic studies of complex disorders like OCD require a very large number of families. Many families have already volunteered their time and effort to help in some genetic studies already underway and results from those studies have been instrumental in helping researchers to understand more about the inheritance of OCD and related conditions. However, many more families are needed. If you are interested in participating in genetic studies, please contact the Obsessive Compulsive Foundation to learn more about how you can become involved.

Bio-Behavioral Institute: In 1

(continued from page 7)

cal team reviews the case in order to design the most appropriate treatment program. Recommendations may include follow-up neuropsychological assessments, medical evaluations, as well as psychological and/or psychiatric treatment. Intensive treatment may be recommended on either an inpatient or outpatient basis, depending on many factors, including the functioning level of the patient and severity of the illness. Our out-of-town patients often stay at a local hotel for the duration of the program.

NEWSLETTER: What is the length of your Intensive Treatment Program?

NEZIROGLU: It varies, but typically consists of one to two months of intensive treatment followed by a gradual reduction in session frequency. We then follow that up with a maintenance program.

NEWSLETTER: What alternatives do a patient have if s/he hasn't achieved a satisfactory remission of symptoms at the end of your program?

NEZIROGLU: We strongly advise our patients to continue in treatment for approximately one year after completing an initial intensive treatment program. We offer sessions via the telephone for patients who do not reside in the area. If necessary, we ask a patient to return for further treatment. For patients who initially wanted to try behavior therapy without medication, we recommend they try a combined approach. Also, it may be necessary to implement other forms of treatment in order to increase improvement, such as, dialectical behavior therapy for borderline patients; cognitive therapy for depression; or marital/family therapy.

NEWSLETTER: OCD is a chronic illness so relapse is a big issue. How does the Institute's program deal with the relapse issue?

NEZIROGLU: An important component of our treatment is to teach patients about relapse prevention and maintenance of treatment gains. We make every effort to educate our patients about factors that can contribute to a relapse during and after intensive treatment. We have a relapse prevention program. In fact we have published two studies looking at the effect of our relapse prevention program for OCD and body dysmorphic disorder. To date, only three studies have been performed looking at the efficacy of relapse prevention programs; and ours have shown that patients who engage in this

post treatment do a lot better in the long run.

NEWSLETTER: Is follow-up treatment available for individuals who have completed your Intensive Program?

NEZIROGLU: Yes, we actually strongly advise them to continue. Patients who live in the area can obviously continue at Bio-Behavioral and out of state patients can continue on the phone.

NEWSLETTER: If a program participant's OCD involves his/her home environment and he/she lives relatively close to the Institute, will staff members visit the patient's home?

NEZIROGLU: Yes, we often do home visits as well as phone sessions for patients who would benefit from them. In fact, many patients may be unable to come to the Bio-Behavioral Institute. For those patients, we will see them at their homes. For patients who may have contamination concerns or patients who are homebound due to their body dysmorphic disorder, we have even resorted to talking to patients through a door or window so that they feel less exposed to their fear. We will do whatever we need to do in order to make things easier initially for the patient.

NEWSLETTER: Do you treat children and adolescents at Bio-Behavioral as well as adults? If so, what age range will you treat?

NEZIROGLU: Our population does range from childhood to adulthood and we treat all age ranges. We have children as young as three years of age and adults as old as 88. We had one patient recover after having had OCD for 66 years.

NEWSLETTER: Do you offer an Inpatient Intensive Treatment Program as well as an outpatient program? Which hospital is involved with your program?

NEZIROGLU: We offer both an inpatient and outpatient program. Our staff is affiliated with North Shore University Hospital in Manhasset, New York.

NEWSLETTER: Does the Institute also offer non-intensive OCD treatment?

NEZIROGLU: Yes we do. Session frequency and length are determined by the severity of the patients' illness and vary on an individual basis. Some individuals need to get better by a certain time frame, i.e., students going back to school or people whose jobs are in jeopardy, etc. These patients usually opt for an intensive pro-

gram. However, there are many patients who come in only once a week. These are individuals who are generally experiencing distress and have mild to moderate OCD, but their functioning is only minimally impaired.

NEWSLETTER: What factors should a patient consider when he/she is trying to decide whether to go into an Intensive Treatment Program?

NEZIROGLU: That is hard to say. However, as I said before we have been doing this for nearly three decades and we have treated over 3,000 patients. We offer a scientific, artistic and humanistic approach. What I mean by this is the following: We are scientists because we conduct research and are interested in finding out what works for whom. We have published extensively and written many books and chapters on the disorder. We have the art to treat because we can sense our patients after such a long time of treating them and by now we are very attuned to their thoughts and feelings. We are humanistic because we see the individual as a whole. A person has OCD; s/he is not the illness. We attend to our patients' and the family's needs. We are there with them all the way through. We have spent our lives doing this work so we are very invested in seeing our patients get better. Our staff members are hired based on their talents as well as their capacity to give as individuals. They know OCD and the Spectrum Disorders and have been well trained by us.

NEWSLETTER: Can you describe the beginning phase of the Institute's Intensive Treatment Program?

NEZIROGLU: The focus of the first 3 to 4 days of an intensive program is to better assess the patient's illness, educate the patient about treatment and the disorder, and design the most effective treatment approach. Our therapists gather a complete psychological and psychosocial history and assess the current symptoms. We often use standardized self-report and interview questionnaires to aid in this process.

NEWSLETTER: What is a typical day in your program?

NEZIROGLU: Patients meet with their individual therapists on a daily basis and continue cognitive or behavioral treatment and are given daily homework assignments. These assignments help a person to master the skills they have learned that day. We work with families where appropriate and have them assist in the treat-

The Forefront of Treating OCD

ment. When a patient is hospitalized, s/he will also participate in various group therapies throughout the day.

NEWSLETTER: What is the program's staff-to-patient ratio?

NEZIROGLU: Each patient has a therapist assigned to him or her. Sometimes during the intensive phase a patient may work with two therapists. It is almost a one to one ratio.

NEWSLETTER: What are the improvement rates of your program?

NEZIROGLU: At the end of the intensive phase there is an average rate of 75 percent reduction in symptoms. After that, the patient continues treatment on a weekly basis dealing with his/her residual symptoms. In addition, we work with other areas of the patient's life, i.e., dating, returning to work, school, marriage, etc. I would like to emphasize that we treat the individual as a whole. In other words, besides their OCD or because of their OCD, we look at what other areas of the individual needs remediation. For example, patients may have a great deal of fear about returning to work or school, or beginning to date or socialize again. Old wounds sometimes need to be repaired, i.e., anger, resentment, embarrassment, etc. When you talk about improvement rate, we just quoted you a symptom reduction rate but actually improvement occurs when all these areas are dealt with.

NEWSLETTER: What factors should someone consider when s/he is trying to determine if the Institute's Intensive Program is appropriate?

NEZIROGLU: Out-of-state patients may set up telephone consults to determine if it is worthwhile for them to come to New York. Appropriateness for treatment will be determined during the first consult visit.

NEWSLETTER: What are your criteria for admitting a patient to your program?

NEZIROGLU: We believe it is worth trying to help anyone who is willing and motivated to receive help. We often take on patients who have not succeeded in other programs; and, in fact, often other programs will make such referrals since the doors of Bio-Behavioral Institute are open to almost everyone.

NEWSLETTER: Can individuals with comorbid conditions or substance abuse problems be admitted to your Intensive Treatment Program?

NEZIROGLU: Many of our patients suffer from comorbid conditions. If patients have substance abuse, sometimes we may recommend a separate program at another facility to first address that issue. However, it depends on the degree of usage and reason. We have found many patients with anxiety disorders use alcohol as a way of self-medicating. Other comorbid conditions besides substance abuse are addressed during treatment. About 50% of patients generally have another comorbid condition. It is not a problem; it just needs to be addressed.

NEWSLETTER: What kinds of research are you and the staff at Bio-Behavioral involved in at this time? Are there any research programs available for sufferers to participate in?

NEZIROGLU: At the present moment we are conducting research on self-mutilation, body dysmorphic disorder, overvalued ideation, hoarding and the role of cognitive rehabilitation in adherence to treatment.

NEWSLETTER: Are your services covered by private insurance? Medicare? Medicaid?

NEZIROGLU: The level of coverage for our treatment is dependent on the type of private insurance the patient has. Many of our patients do receive partial out-of-network reimbursement for treatment. We do accept Medicare and the hospital accepts both Medicare and Medicaid.

NEWSLETTER: If a client does not live within commuting distance of Bio-Behavioral what facilities are available for him/her while participating in your program?

NEZIROGLU: We have local hotels in the area that are a short cab ride from the Institute. We are also close to public train and bus transportation.

NEWSLETTER: Who treats OCD and the Spectrum Disorders at Bio-Behavioral? Could you outline their experience and training for our readers?

NEZIROGLU: We have psychiatrists, licensed psychologists, assistant psychologists (those who have a Ph.D. but have not fulfilled taken their New York State licensing exams yet), therapists (those who have completed all course work for their Ph.D., but who have not completed their research for their dissertation) and psychology interns. All staff members are supervised and usually have quite a bit of experience at Bio-Behavioral before they

take on individual patients. We have ongoing meetings to discuss patient care as well.

NEWSLETTER: The staff at Bio-Behavioral has been very active in treating the OCD Spectrum Disorders also. Can you talk about the various Spectrum Disorders and the treatment modalities Bio-Behavioral staff uses?

NEZIROGLU: We also offer similar programs for the Spectrum Disorders, including body dysmorphic disorder, hypochondriasis, self-mutilation, and trichotillomania. For body dysmorphic disorder and hypochondriasis, we have found that employing cognitive techniques before behavior therapy is the most effective. We use a variety of approaches for trichotillomania and self-mutilation from exposure and habit reversal to family intervention.

NEWSLETTER: Does Bio-Behavioral have any programs to provide assistance to an individual who does not have any financial resources to pay for treatment? If an individual participates in any of your research programs, will he/she receive treatment at no cost?

NEZIROGLU: We do have research protocols that are conducted at Bio-Behavioral which enable patients to receive low cost treatment. At the current moment we are offering a treatment program investigating relapse prevention in obsessive compulsive versus body dysmorphic disorder. At different times we have different research protocols and it is best for the patient to inquire periodically.

NEWSLETTER: What kind of follow-up program does Bio-Behavioral offer?

NEZIROGLU: We have a relapse prevention program whereby individuals call or come to the office for shorter periods of time after treatment has been terminated. Also patients may come back for booster sessions at any time.

NEWSLETTER: If someone is interested in more information about the Institute's programs, whom should he/she contact?

NEZIROGLU: Anyone who is interested may obtain more information from our website www.bio-behavioral.com. They may also write to Bio-Behavioral Institute, 935 Northern Blvd., Great Neck, NY 11021 or call 516-487-116 to get a brochure. You can also contact Dr. Sony Khemlani, our Administrator, for information about the program as well as Gloria Brech, our Office Manager, for information about fees and insurance coverage.

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