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OCD Newsletter

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Scientific and Theological Perspectives on Scrupulosity: A Panel Discussion

Moderator: David F. Tolin, Ph.D., Anxiety Disorders Center, The Institute of Living, Hartford, CT

Panelists:

Father Joseph Donnelly, Pastor, Roman Catholic parish, Hartford, CT

Rev. Melanie Enfield, Minister, United Church of Christ

Rabbi Philip Lazowski, Conservative Jewish Congregation Rabbi

A Roman Catholic man worries excessively that he has not fully confessed to all of his sins. An Orthodox Jewish woman feels a need to check and re-check her house for a crumb of leavened bread during Passover. These worries and behaviors are examples of scrupulosity, obsessive thoughts and compulsive behaviors or mental acts that relate to religious, ethical, or moral matters. Scrupulosity has long been recognized as a subtype of OCD.

Indeed, the field trial for the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, identified religious themes as the fifth most common domain of obsessive thoughts (Foa et al., 1995). In a multisite sample of patients with OCD, eighteen percent reported religious obsessions (Mataix-Cols et al., 2002); these obsessions tended to remain constant over a two-year period.

Research on scrupulosity has identified two major themes of religious obsessions: that one has committed or will commit sins, and that one will be punished by God (Abramowitz, Huppert, Cohen, Tolin, & Cahill, 2002). Although some people with scrupulosity obsessions recognize that their fears are excessive, others can be quite convinced that their fears are valid (Tolin, Abramowitz, Kozak, & Foa, 2001). These obsessions are usually functionally

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Compulsive Hoarding: New Developments in Treatment and Research

By Gail Steketee, Ph.D., Professor, Boston University School of Social Work

Randy Frost, Ph.D., Professor, Smith College

Hoarding behavior includes the acquisition of and failure to discard possessions that appear to be useless or of limited value. It is not, in and of itself, pathological. However, when it results in living spaces that are so cluttered that using them for their intended purposes is not possible, and when it causes significant distress or impairment in functioning, then the behavior is a problem. The compulsive hoarding syndrome manifests in three problematic behaviors: compulsive acquisition either through buying or collecting free things, inability to discard possessions that are not needed, and significant clutter and disorganization of possessions within the individual's living spaces.

The problems associated with hoarding (acquisition, difficulty discarding, clutter) all develop at around age 18, but typically don't become severe until after age 30. People with hoarding problems are less likely to marry and more likely to live alone than people without this problem. They are also more likely to have a family history of hoarding behavior. Recognition of hoarding as a problem varies. Some people recognize the problems created by their behavior while others fail to do so, sometimes despite living in unsafe and unhealthy environments. Often the hoarding behavior creates fire hazards, increased risk of falling (particularly among the elderly), unsanitary conditions, social restrictions, home odors, unusable appliances, and restrictions on necessary activities of daily living (e.g., bathing, paying bills, cooking, etc.).

Hoarding is associated with both obsessive compulsive personality disorder (OCPD) and obsessive compulsive disorder (OCD). With respect to OCPD, hoarding is associated with perfectionism, indecisiveness, and attention to

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Rogers Memorial to Provide Scholarships

The Rogers Memorial Hospital Foundation in Oconomowoc, Wisconsin, recently announced a scholarship program for patients of the Obsessive-Compulsive Disorder Center at Rogers Memorial Hospital in Oconomowoc, Wisconsin. Rogers Memorial Foundation Executive Director Judi Bessette explained, "We developed this program to provide residential or acute inpatient treatment for individuals who suffer from severe OCD and need residential or possibly acute treatment, but do not have the financial resources to cover the entire cost of their stay."

The Rogers Memorial Hospital Foundation is a not-for-profit foundation that raises money to support Rogers Memorial Hospital's programs and services. "One of those programs is providing scholarships for patients in need. In 2000, we began giving a limited number of care continuation scholarships to people in the hospital's residential programs that treat alcohol and substance abuse, eating disorders and OCD," said Bessette. "These scholarships are awarded to individuals who were doing well in their program even though their personal resources and insurance benefits had been exhausted. Implementing this new ODC scholarship program through the Foundation enables Rogers Memorial to serve significantly more OCD patients in need," she added.

The OCD Center at Rogers Memorial Hospital offers residential treatment for men and women age 16 and older with severe and difficult-to-treat cases of OCD. "Each

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In This Issue

Please Support the OCD Genetics Consortium

Bulletin Board

Research: The Hope for Tomorrow

Families with Obsessive Compulsive Disorder are invited to help scientists learn more about the causes of OCD. A team of scientists at six academic institutions is investigating genetic factors which may increase the susceptibility to OCD. Recent advances in molecular biology and statistical genetics make it possible to identify and describe specific genes that may cause complex diseases, such as, OCD. We are seeking families with OCD to help us conduct these studies.

YOU CAN HELP!

If at least two members of your family are diagnosed with OCD or exhibit symptoms, your family might be eligible for this nationwide study. Participation includes a confidential interview and a blood sample. The interview will be scheduled at a time and place convenient for the participant. Participants will be compensated. Families may be referred by a clinician or may contact us.

To learn more about the study, please contact (collect calls accepted):

* Rhode Island region
Maria Mancebo (401)-455-6216
mmancebo@butler.org
* Boston region
Beth Gershuny (617)-726-7866
bgershuny@partners.org
or Katherine McMullan (617) 726-5594
mcmullin@hmr.mgh.harvard.edu
* New York region
Jessica Page (212)-543-6509
* Los Angeles region
Melody Keller (310)-825-4132
mkeller@mednet.ucla.edu
* Washington DC and nationwide
Diane Kazuba
Local: (301)-496-8977
Toll-free: 1-(866)-644-4363
kazubad@intra.nimh.nih.gov
* Maryland and all other regions
Krista Vermillion (410)-575-7326
jacks@jhmi.edu

The OCD Collaborative Genetics Study includes Brown University, Columbia University, Johns Hopkins University, Massachusetts General Hospital, National Institute of Mental Health and UCLA.

New Childhood Obsessive-Compulsive Disorder Study

The National Institute of Mental Health has just begun a new study for children with Obsessive-Compulsive Disorder. The study is enrolling boys and girls ages 4-17 who have experienced a recent onset of OCD (within the last 6 months) and who live within a 4-hour commute of Bethesda, MD. The children will be followed at 6-week intervals for 2 years. The purpose of the study is to learn more about childhood Obsessive-Compulsive Disorder in order to provide early identification and better treatment for children suffering with OCD. The hypothesis of the study is that two groups will emerge: 1) children with a gradual onset and stable course of OCD who will comprise the "persistent" group, and 2) children displaying an acute onset and episodic course of OCD, the "episodic" or PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcus) group.

Benefits to participants and their families include psychiatric, neurological, and physical examinations; psychological testing; and MRI scans. Participants and their clinicians will have the opportunity for consultations regarding medications and cognitive behavioral therapy with clinicians who specialize in childhood-onset OCD.

All care is free of charge. Travel stipends are available to families who reside over 90 miles from the NIMH. Dr. Susan Swedo is the Principal Investigator. For more information and a confidential screening, please call Ms. Maggie Pekar, M.A. at: (301) 496-5323, or email: PANDAS@codon.nih.gov.

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

Participants are needed for an NIMH-sponsored study that is designed to prospectively follow the long-term course of OCD in individuals with a primary diagnosis of OCD. This study is the first one of its kind, and will ultimately provide important new information about many aspects of treatment and the assessment of OCD.

This is an interview study with annual follow-ups. Participants will be paid $25 for the first interview and $40 for annual follow-up interviews. Participation is strictly confidential. Individuals (ages 6 and older) who have been diagnosed with OCD and have sought treatment for their OCD symptoms within the past 2 years are eligible to participate. Participants must be able to come to Rhode Island at least once for a face-to-face interview. Screening for this study takes approximately 10 minutes on the telephone.

Please contact:
Maria Mancebo, Ph.D.
Butler Hospital
345 Blackstone Boulevard
Providence, RI 02906
(401) 455-6216
mmancebo@butler.org

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OCD NEWSLETTER

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Obsessive Compulsive Foundation, Inc.
Phone: (203) 315-2190
Fax: (203) 315-2196
e-mail: info@ocfoundation.org
www.ocfoundation.org
Janet Emmerman, President, Board of Directors
Patricia B. Perkins, J.D., Executive Director/Newsletter Editor
Michael Jenike, M.D., Chairperson, Scientific Advisory Board

The Obsessive Compulsive Foundation (OCF) is an international not-for-profit advocacy organization with more than 8,000 members worldwide. Its mission is to increase research, treatment and understanding of Obsessive Compulsive Disorder (OCD). In addition to its bi-monthly newsletter, OCF resources and activities include: an annual membership conference; popular website; training programs for mental health professionals; annual research awards; affiliates and support groups throughout the United States and Canada; referrals to treatment providers; and the distribution of books, videos, and other OCD-related materials through the OCF bookstore; and other programs.

Finch Program Provides Latest Developments in Psychosocial Intervention to Help People with OCD

The following is an interview with John Calamari, Ph.D., associate professor and director of the Anxiety & OCD Treatment and Research Program at the Finch University of Health Sciences in North Chicago, IL.

NEWSLETTER: What treatment programs for OCD are available at the Anxiety & OCD Treatment and Research Program at the Finch University of Health Sciences?

DR. CALAMARI: We offer cognitive behavioral therapy for OCD for adults, adolescents and older children. We offer an intensive therapy option for individuals with more severe OCD. Intensive treatment typically involves 90-minute sessions three to five times per week for three to four weeks. All of our treatment is provided on an outpatient basis.

NEWSLETTER: What treatment modalities do you employ in your intensive treatment program? Do you use both medication and exposure and response prevention therapy (ERP) in your intensive treatment program? Any other treatment techniques?

DR. CALAMRI: The intensive program involves vigorous exposure and response prevention treatment. Exposure therapy is graduated and emphasis is placed on helping participants reduce ritualizing as quickly as possible. In recent years we have placed greater emphasis on conducting concurrent cognitive therapy where beliefs specific to OCD are evaluated (e.g., the importance of thoughts and mental control) or more general beliefs (e.g., the dangerousness of intense anxiety) are addressed. Referral to university or community psychiatrists is available for individuals needing medication management. Many of the program participants are referred from community psychiatrists. These individuals have typically received the maximum benefit possible from medication, but remain highly symptomatic.

NEWSLETTER: What is the treatment philosophy behind your program?

DR. CALAMARI: The guiding philosophy of the program is to apply the latest developments in psychosocial intervention to help individuals treat their OCD. Program participants learn a variety of empirically supported strategies for managing their OCD and for developing needed life-skills.

NEWSLETTER: What is the length of your intensive treatment program? Is the time period tailored to an individual patient's availability or is the program for a set period of time?

DR. CALAMARI: Intensive therapy typically involves 90-mimute sessions three to five times per week for three to four weeks, but the frequency of treatment is often adjusted in response to many practicalities (e.g., work and school). For example, an adult might start intensive treatment by taking a single week of vacation time. We might see that person for five days that first week and reduce the frequency of contact to two times per week for the next five or six weeks due to his/her job responsibilities. We attempt to make doing treatment, at the intensity necessary for the person to beat his/her OCD, practical. We attempt to help potential participants minimize reasons to put off pursuing needed treatment.

NEWSLETTER: What level of severity of OCD is your program geared toward? Moderate? Severe? Treatment refractory?

DR. CALAMARI: We work with individuals at all levels of severity, although during the last ten years we have seen progressively fewer people at our program with mild OCD. Infrequently, we evaluate individuals who cannot be safely treated on an outpatient basis and we refer these people to the inpatient program at the University of Illinois or to the Rogers Memorial Hospital residential program in Wisconsin.

NEWSLETTER: How many clients at a time are in your intensive program?

DR. CALAMARI: We typically have approximately 20 patients in treatment at any one time with one or two individuals involved in intensive therapy.

NEWSLETTER: Do you have residential facilities for individuals in your program or do they need to commute or stay at a local hotel?

DR. CALAMARI: There are no residential or inpatient facilities available at the program. When we do work with people from out of state they will often stay with relatives in the Chicago metropolitan area or stay in a local hotel.

NEWSLETTER: Is your intensive program open to only adults or do you also treat adolescents and children in this program?

DR. CALAMARI: We will treat adolescents and older children in our intensive program. I do not consider myself expert in working with young children (i.e., less than about ten); therefore, we refer those families to other OCD experts.

NEWSLETTER: Would you describe the typical course of treatment in your program? Where does a patient start with CBT and ERP and where do you expects him to be at the end of the program?

DR. CALAMARI: Our intake process begins with potential participants completing an assessment packet, a collection of OCD specific and general anxiety and depression self-report measures. This provides us with an initial picture of symptoms and the severity of any concurrent problems (e.g., the severity of depression). Once the packet is sent back, an intake evaluation is set up. The intake evaluations involve about four hours of clinical assessment. This evaluation process allows us to obtain a highly detailed picture of the individual's OCD and to evaluate whether other anxiety problems are present.

During this process, behavior therapy is explained and an attempt is made to identify potential barriers to the successful completion of behavior therapy. Cognitive therapy might be emphasized first for individuals who maintain overvalued beliefs about their OCD. When behavior therapy is initiated, a hierarchy is structured and participants set out to systematically break the rules of their OCD starting with the less challenging issues. By the end of the program we want the participant to have completely challenged every aspect of his OCD to increase the likelihood of maintaining gains. Certain OCD specific beliefs must also be challenged (e.g., all my thoughts are important). This is an important component of treatment if gains are to be maintained.

NEWSLETTER: Can someone be in your program who has never done ERP therapy?

DR. CALAMARI: We see many people who have not been involved in ERP previously. Unfortunately, many of these individuals have had OCD for many years and the problem has not been diagnosed or they have been involved in treatment that has not been effective.

NEWSLETTER: What part does medication play in your program? Can someone be in your program who doesn't wish to use medication? Should a person start medication before he enters the program?

DR. CALAMARI: We understand behavior therapy, medication and cognitive therapy as the three empirically supported interventions for OCD. All approaches are used in our program. Again, a typical referral is from a community psychiatrist where the best effect that can be had from modern medications has been obtained, but the individual remains symptomatic. We prefer medications to have been stable for at least several weeks before behavior therapy is initiated. We have taken this position in response to the repeated observation that if both medication and behavior therapy are initiated at the same time, individuals want to give the credit to the drug rather than to all their hard work.

NEWSLETTER: How do you determine what medication a participant should be on?

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Compulsive Hoarding: New Developments in Treatment and Research

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detail at the expense of the bigger picture. With respect to OCD, hoarding seems to form a separate factor or subtype of this disorder that contrasts with cleaning, checking, and ordering/symmetry. Hoarding occurs in approximately one-third of people with OCD and is a major symptom in 4 to 11%. Hoarding shares some similarities with other OCD symptoms, particularly, doubting, checking and the need for reassurance before discarding. Also, the frequency and severity of OCD symptoms among people who hoard are similar to those of other OCD cases. People with compulsive hoarding differ from those with other OCD symptoms, however, in that their hoarding behavior does not always cause distress and insight into the problem is often low. Further, they do not tend to respond as well to treatments that are effective for other forms of OCD.

Based on our research on this topic, we have formulated a cognitive behavioral model of compulsive hoarding. This model postulates that hoarding is a function of four deficits or problem areas including information processing problems, problematic beliefs about and attachments to possessions, emotional distress associated with possessions, and avoidance behaviors designed to limit the experience of distress.

The information processing problems hypothesized to play a role in compulsive hoarding include four types. Attention focus is often difficult to maintain among people with this problem, and our preliminary findings suggest some overlap with attention deficit disorder. Categorization is an important basis for how most people organize their lives and find things they need. Objects are categorized and placed in locations based on the category to which they belong. People with hoarding problems appear to have difficulty organizing objects and papers categorically, and instead do so based on a visual/spacial system that is unfortunately highly inefficient. Many people with hoarding problems also complain of memory deficits. Although they may have some problems with non-verbal memory, it appears that lack of confidence in memory contributes to this problem. Finally, people who hoard seem to have difficulty using information to draw conclusions and make decisions. Decision-making problems may extend beyond decisions about possessions and appear in many life contexts.

Beliefs about and emotional attachments to possessions include beliefs about being responsible for the well-being of possessions, beliefs about memory ("Saving this means I don't have to rely on my memory") and beliefs about control over possessions. Also, possessions come to hold emotional meanings involving one's sense of identity ("Throwing this away is like throwing away part of me"), feelings of comfort and security ("I can't tolerate getting rid of this"), and feelings of loss or grief ("Throwing this away feels like abandoning a loved one"). Emotional distress associated with hoarding occurs most often when attempts are made to get rid of possessions. When considering whether or not to keep a possession, the beliefs and emotional attachments described above create considerable anxiety. These thoughts can be so distressing that alternative thoughts about whether the person actually uses the objects or wants it taking up much needed space at home are never considered.

To avoid the experience of distress/anxiety and the effort required to make a decision to discard, people with a hoarding problem typically save possessions. Keeping them enables people to avoid distressing thoughts about loss, security, etc., and troublesome decision-making. However, avoiding these things leads to homes filled with clutter, and also prevents the person from learning to challenge faulty beliefs about the value of possessions. The beliefs become more entrenched and serve as guides to further hoarding behavior.

Treatments for compulsive hoarding can include medication, traditional cognitive and behavioral therapy (CBT) methods like those usually used for OCD, and hoarding-specific cognitive-behavioral treatment that targets the aspects of hoarding described above. The serotonergic reuptake inhibitors (SRIs) that are usually effective with OCD have also been tried for hoarding, but with poorer results. Black and colleagues (1998) treated 38 patients with OCD of whom 17 had hoarding symptoms. Twenty patients received paroxetine, 10 patients received 12 sessions of CBT that focused on correcting overestimation of harm and responsibility, and 8 received placebo medication. Despite a 50-60% response to the SRI and CBT among non-hoarding OCD patients, only 18% of those with hoarding problems had a good response to treatment. Thus, hoarding symptoms predicted poor treatment response.

This poor response to serotonergic medications has also been found by other researchers. Mataix-Cols et al. (1999) provided various SRI medications to 150 OCD patients of whom 20% had hoarding as a current problem and 6% had hoarding as their primary problem. Hoarding symptoms predicted poorer outcome after treatment according to standard measures of OCD severity. In another study by Winsberg and colleagues (1999), 20 patients who had hoarding and other OCD problems were treated with SRI medications. About half of the patients improved to some extent, but only one patient had a strongly positive response. In addition, 9 patients also received CBT with their medication; one third of these had a good response, but overall the outcomes were considered disappointing with these traditional forms of treatment.

Quite recently, Mataix-Cols and colleagues reported the effects of various treatments for 153 OCD patients who received some form of behavior therapy. About a third got a brief computerized form of this treatment, and another third were give exposure treatment by a therapist who assisted them. The remaining group listened to an audiotape of relaxation as a placebo therapy. Among the patients, 34% had hoarding symptoms and having this problem predicted more dropping out and less positive response to the therapy. So again, hoarding seems to respond less well to treatments that have worked for OCD traditional symptoms. These findings raise serious concerns about what treatments are appropriate for hoarding problems. We have recently developed a multicomponent CBT strategy for treating hoarding problems based on the model described earlier. We believe this method will improve outcomes compared to previous methods.

Treatment includes the following components: motivation enhancement, assessment and education about hoarding, interventions for aiding in organizing, reducing acquisition, facilitating discarding and preventing relapse. To improve insight into the problem and its effects and to enhance motivation for resolving the hoarding problem, the therapist employs motivational interviewing techniques described by Miller and Rollnick (2002). This includes helping the patient work out concrete goals that focus on improving functioning and establishing rules for therapy that require that clients make all the decisions about their own possessions. Homework is assigned and home visits are arranged whenever possible. Group treatment may provide additional support. Treatment goals include the following: create living space, increase appropriate use of space, improve decision-making skills, organize possessions, discard unneeded items, and prevent future acquisition and excessive saving.

Treatment begins with a comprehensive assessment of several topics. These include medication use, specific problems with acquisition, clutter, and difficulty discarding, role of family and friends, usual social life, health concerns if any, OCD and mood problems, family history, especially of hoarding, history and previous treatment for hoarding problems, and any involvement of outside agencies (e.g., fire, police, elder services) in hoarding problems. Therapy begins with defining the problem of hoarding and explaining the CBT model we have described earlier, as well as a description of treatment. We then work on organization by deciding on goals and developing a list of categories and locations for saved items and for unwanted items to be discarded, recycled, donated or sold. The therapist and patient develop a plan for sorting and filing; and then during its implementation, the therapist helps the patient identify problematic thinking and beliefs about possessions.

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Compulsive Hoarding

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The next step is to identify patterns of behavior that provoke excessive acquiring and to help people curb these. Strategies for this include visualizing not buying or collecting desired objects, helping patients expose themselves to such situations without acquiring and using cognitive methods to alter problematic beliefs. For discarding, the therapist uses imagined and actual exposures to discarding saved items. Several cognitive strategies are used, including estimating the probability of harm after discarding, evaluating need versus want, listing advantages and disadvantages of discarding, and taking another perspective regarding the value of objects. Finally, the therapist and patient discuss ways to prevent relapse. These might include scheduling time for organizing and discarding, inviting visitors home regularly, anticipating stressors and their effects, applying skills learned in treatment, and identifying resources for future needs.

This treatment method has been tested in case studies and in a group intervention. In one case study by Hartl and Frost (1999), a 53-year-old woman with 2 children who also had washing compulsions responded very well to therapy home visits using the methods described above. At 9 months, she had improved by 35%. In another unpublished case, a 60-year-old woman who owned multiple houses filled with her possessions was treated with similar methods. She took regular photographs of her home to guide the therapy. After 12 sessions, she improved on acquisition, shopping, saving and clutter, as well as on decision-making. By the end of therapy, her home was considerably more usable and better organized. Cermele and colleagues (2001) have also reported success using very similar methods for a 72-year-old woman who was treated in an intensive one-day therapy with considerable preparation and follow-up after the treatment ended.

Two studies have examined the outcomes of this specialized CBT for hoarding with larger samples. We (Steketee et al., 2000) reported moderately good success with 15 sessions of treatment for 7 patients with primary hoarding problems, 6 of whom were treated in a group. Acquisition, insight, decision-making, organizing skills and clutter improved moderately, with greater improvement evident for the four clients who remained in therapy for several months. Finally, Saxena, Maidment and colleagues (2002) reported good outcomes for a very severe group of 20 people who attended an intensive treatment program and received 6 weeks of daily individual and group therapy focused on hoarding problems. Symptoms reduced by at least a third for most patients and functioning also improved considerably. Overall, then, this specialized treatment for compulsive hoarding holds promise and should be tested in larger groups of patients with hoarding as their primary problem.

This article represents the first in a series of articles on Obsessive Compulsive Hoarding.

Rogers Memorial Hospital Foundation Providing Treatment Scholarships

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patient's treatment plan is individualized, but all plans use a strict Cognitive Behavioral Therapy (CBT) approach emphasizing exposure and ritual prevention," said Bradley C. Riemann, Ph.D., clinical director of the OCD Center at Rogers Memorial. "Because of the severity and complexity of these cases, a combination of CBT and medication is used."

Paul Mueller, COO of Rogers Memorial-Oconomowoc, said that the scholarships would cover charges for daily rates in the residential program at the OCD Center. If a patient needs acute stabilization, the scholarship would cover inpatient care at Rogers Memorial Hospital. "Under the scholarship, patients are responsible for all medical, laboratory and pharmacy/medication expenses," said Mueller. "There also will be a $25 per day co-pay for the residential program and a $50 per day co-pay for the inpatient program. We're asking for this co-pay so that individuals will be invested in their treatment."

The Foundation has designated $80,000 annually for the OCD Scholarship Program. It is expected that this $80,000 will cover approximately 200 treatment days in the OCD residential program at Rogers Memorial. The residential intensive OCD program is typically 65 days in length.

"The OCD Center clinical staff will determine a prospective patient's eligibility based on the submission of a completed application packet and assessment information provided by the healthcare providers of a prospective patient," said Dr. Riemann in describing the selection process. "The patient accounting staff at Rogers Memorial will review the financial needs of applicants. The actual administration of the scholarship program will be done by the Rogers Memorial Foundation," he added.

There is a section on the application that requests financial information. In making a determination of financial need, Mueller said that the patient accounting staff "will be looking at an applicant's income including salary, long term disability insurance, social security benefits, family resources and trusts."

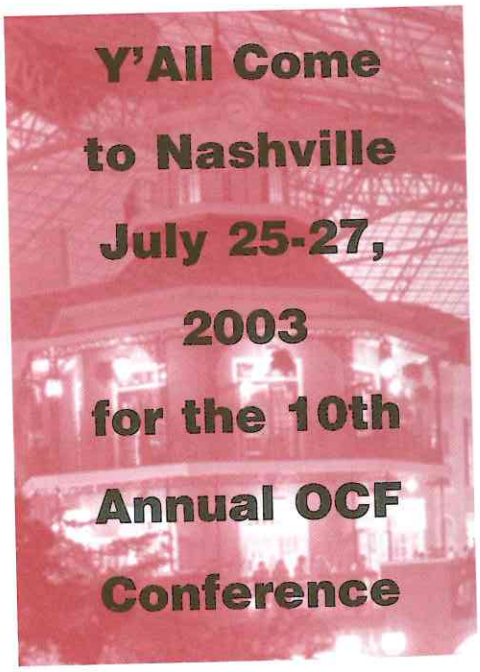
Mueller also noted that having private or governmental insurance coverage would not exclude a person from consideration for a scholarship. "Each case will be screened based on its individual, financial and clinical circumstances," said Mueller. "The applicants with insurance will be considered for a scholarship if their insurance will not pay for residential or inpatient services."

Dr. Riemann noted that applications would be accepted on a rolling basis. "The average time for processing each application is expected to be between two and three weeks," said Dr. Riemann. "Once an application has been submitted, the applicant will be reviewed for clinical need and appropriateness of treatment," he added. "We will be looking for individuals who are suffering from severe OCD and are motivated to participate in treatment."

"While the severity of an applicant's OCD is one of the factors that will be considered," said Dr. Riemann, "each case will have individual considerations that will be factored into the decision-making process. At times, there may be certain individuals who may not be appropriate for our services."

According to Dr. Riemann, if an individual is doing well in his or her treatment regimen but has not reached maximum improvement before his or her scholarship runs out, the OCD clinical director and treatment team will decide if continued treatment is appropriate. Dr. Riemann said, "The genesis of the OCD scholarship program was a more informal system we had been using when this situation occurred. Prior to initiating this program, we had been going to the Rogers Memorial Foundation when someone needed financial assistance to stay on and continue treatment when his or her insurance had reached its coverage limit."

For more information on the Rogers Memorial Hospital Foundation OCD Scholarship Program and an application, write to: OCD Scholarship Committee, Rogers Memorial Hospital, 347000 Valley Road, Oconomowoc, WI 53066, or call 1-262-646-1336 or 262-646-4411, ext. 436.



Research Digest

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

As this year begins, we've chosen to present a potpourri of topics. Gambling is a growing problem in our society, so two articles are reviewed on this topic. We'll continue this theme from time to time in 2003 as other important data emerge. We've presented further data supporting a familiar theme: cognitive-behavioral therapy (CBT) added to serotonin reuptake inhibitors (SRIs) is almost certainly the best treatment for OCD – the main difficulty is finding competent CBT therapists. And, with the holidays as a stimulus for eating, we'll start with a caution especially relevant for OCD sufferers.

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

Serum cholesterol level comparison: control subjects, anxiety disorder patients, and obsessive-compulsive disorder patients

Canadian Journal of Psychiatry, 47:557-561, 2002, H. Peter, I. Hand, F. Hohagen et al.

Serum cholesterol levels of 60 anxiety disorder patients, 60 OCD patients and 60 normal control subjects were compared. Patients with anxiety disorders and OCD had elevated cholesterol levels compared with normal control subjects. The U.S. National Education Program has set up guidelines to classify total cholesterol levels. According to these guidelines, 65% of OCD patients, 68% of anxiety disorder patients and 30% of control subjects had borderline high or high cholesterol levels. There have been two previous studies on cholesterol levels in OCD patients, one study found normal cholesterol levels and the other reported increased cholesterol levels. High cholesterol levels are a risk factor for heart disease. Based on their findings, researchers propose that cholesterol levels need to be checked regularly in patients with anxiety disorders and OCD. Patients with substantially elevated cholesterol levels need specific interventions to decrease levels.

Though it's not clear what causes this association of OCD and increased cholesterol levels, stress of dealing with OCD (and anxiety as a general stressor) may be the culprit. Stress increases the body's production of cortisone and that, in turn, may increase cholesterol levels. Effective treatment of OCD and the stress it causes should help correct high cholesterol levels if this thinking is correct. (JHG)

How to recognize and treat the pathological gambler

Current Psychiatry, 1:38-44, 2002, J.E. Grant and S.W. Kim

Guidelines on recognizing and treating pathological gambling are presented. Compulsive gambling is often a secret disorder and, if untreated, it frequently becomes a chronic condition. Males are twice as likely as women to be affected. Consequences can be disastrous; in one study 44% of pathological gamblers had lost all their savings, 24% had filed for bankruptcy, 23% had lost their homes or cars, and 15% had significant marital problems. Treatment with serotonin reuptake inhibitors (SRIs) usually decreases thoughts about gambling, decreases gambling behavior, and improves social and occupational functioning. As in the treatment of OCD, effective SRI doses appear to be higher than the average doses required for depression. Naltrexone (Revia) is also an effective medication. Additionally, there is increasing evidence of the effectiveness of cognitive-behavioral therapy.

Pathological gambling

JAMA, 286:141-144, 2001, M.N. Potenza, T.R. Kosten and B.J. Rounsaville

This is a review of the disorder with emphasis on the need to understand, identify and develop effective treatments for those with gambling problems. Pathological gambling (PG) is a growing problem with significantly higher rates being seen in adolescents. There is a high suicide attempt rate in those suffering PG, 17% to 24% of individuals in Gamblers Anonymous groups reported attempting suicide. At-risk individuals include adolescents, adults in mental health and substance abuse treatment, males (pathological gambling in men has been found to be 2 to 3 times higher than in women), African Americans (31% of individuals diagnosed), individuals with a family history of gambling problems and individuals of lower socioeconomic status. Currently, there are no medications with Food and Drug Administration (FDA) approval for PG. However, there are some data suggesting that SSRIs and naltrexone (Revia) may be effective for some patients.

Addition of cognitive-behaviour therapy for obsessive-compulsive disorder patients non-responding to fluoxetine

Acta Psychiatrica Scandinavica, 106:314-319, 2002, M. Kampman, G.P.J. Keijsers, C.A.L. Hoogduin et al.

Selective serotonin reuptake inhibitors (SSRIs) and cognitive behavior therapy (CBT) are both effective treatments for OCD. This study examined the effects of adding CBT to continued fluoxetine (Prozac) treatment in OCD patients who had not responded adequately to fluoxetine alone. After 12 weeks of fluoxetine, 60 mg/day, 14 of 56 patients were classified as nonresponders. Nine of these 14 patients completed 12 weekly, 50-minute sessions of CBT with a therapist to guide their daily CBT homework in addition to continued fluoxetine treatment. CBT consisted of exposure, response prevention and cognitive therapy. Response to treatment was measured with the Yale-Brown Obsessive Compulsive Scale (Y-BOCS). After the initial 12 weeks of fluoxetine, nonresponders had an average reduction of 8.5% in Y-BOCS scores and after the 12 weeks of CBT with continued fluoxetine there was an average reduction of 41% in Y-BOCS scores. The added CBT lead to a reduction in OCD symptoms for seven of nine patients. Results of the present study are not conclusive because it is possible further improvement might have occurred with even longer treatment with fluoxetine. However, this study does support the value of adding CBT when patients do not improve sufficiently from an initial, adequate trial of an SSRI.

Combination of behavior therapy and pharmacotherapy is superior to pharmacotherapy alone in OCD

International Journal of Neuropsychopharmacology, 5(Suppl 1):S132, 2002, N. Tenney, D. Denys, N. van der Wee et al.

Researchers examined the effects of adding behavior therapy (BT) to drug therapy in patients already responding to the medication. Having responded (Y-BOCS scores decreased from 25.8 to 16.2) after 12 weeks of antidepressant treatment (not further specified), 60 patients completed this 6-month randomized extension study. Twenty-five patients received combination drug and BT and 35 patients received drug only. Patients (including those who dropped out for any reason) receiving the combination treatment had a mean reduction in Y-BOCS scores of 26%

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while patients on drug alone had a mean increase in Y-BOCS scores of 17%. These results suggest that addition of behavior therapy to drug therapy in patients who have already benefited from drug therapy increases the treatment effect considerably.

Context in the clinic: how well do cognitive-behavioral therapies and medications work in combination?

Biological Psychiatry, 52:987-997, 2002, E.B. Foa, M.E. Franklin and J. Moser

Controlled trials comparing combined treatment with medication and cognitive-behavior therapy (CBT) to medication or CBT alone in the treatment of several anxiety disorders were reviewed. For OCD, four studies were reviewed. This review suggests that adding medication does not hinder CBT treatment, but the addition of medication does not enhance CBT. In contrast, addition of CBT enhances medication treatment. It may be that certain groups of patients may benefit from combined treatment. For example, depressed OCD patients receiving combined treatment responded better to the combination than to behavior therapy alone. A clear advantage of combined treatment was not found, but importantly the combined treatment does not impede CBT.

Obsessive compulsive disorder in ultra-orthodox Jewish patients: a comparison of religious and non-religious symptoms

Psychology and Psychotherapy: Theory, Research and Practice, 75:123-130. 2002, D. Greenberg and G. Shefler

Of 28 ultra-orthodox Jewish patients with OCD, 26 had religious symptoms while 18 also had non-religious symptoms. Researchers looked at how individuals viewed the two types of symptoms, speculating that religious symptoms would be less resisted, considered less senseless and carried out more hours daily. Contrary to their speculations, they found that religious and non-religious symptoms of OCD were similarly experienced. Additional findings included people were more likely to turn for help to a rabbi for a religious symptom and to a mental health expert for a non-religious symptom. Also, medication was the preferred treatment for religious symptoms, supporting the view that behavior therapy may be seen as interfering with their religion's rituals.

Genetic Studies in Obsessive-Compulsive Disorder

by Maria C. Rosario-Campos, MD

In the past decade, advances in genetic laboratory techniques and statistical methods have provided the research field with excellent tools for the identification of genetic and non-genetic factors involved in the expression of OCD. Below we describe, in a very summarized way, some of the strategies currently used in OCD genetic studies.

The first step in the search for genes is to establish that a disorder is familial, meaning that having one affected family member with OCD increases the possibility of having other family members affected as well. Family genetic studies compare the rates of a specific disorder among family members of index cases (called case probands) with the rates of the same disorder among the family members of controls (called control probands).

Although initial family studies presented divergent results, more recent ones using comparable methodologies have reported strikingly similar results, with significantly higher recurrence risks of OCD in first-degree family members of case probands (10.3% and 11.7%, respectively) when compared to relatives in control families (1.9% and 2.7%, respectively).

Despite the differences, OCD family studies have consistently reported that the rates of OCD and subclinical OCD among family members is much greater in families where the onset of OCD in the proband is under the age of 17, reinforcing the idea that early-onset OCD patients probably represent a different subgroup of OCD patients.

Another consistent finding is that the rates of tics and/or Tourette's Syndrome are also increased among the relatives of OCD probands, independent of the proband having a comorbid diagnosis of chronic tic disorders. Therefore, it is now believed that OCD is a genetically heterogeneous disorder: some cases are familial and related to tic disorders, some cases are familial and unrelated to tics, and in other cases there appears to be no family history of either OCD or tics.

Twin studies compare the concordance rates for OCD between monozygotic (MZ) and dyzigotic (DZ) twins. These studies are based on the assumption that twins share the same environment but MZ twins share 100% of their genes, whereas DZ twins share only 50% of their genes. Therefore, the higher the concordance rates for MZ twins, compared to the rates for DZ twins, the higher the probability for a disorder to be genetic. OCD twin studies report higher concordance rates among MZ twins (up to 87%), compared to DZ twins (up to 47%). Since the MZ concordance rates are never 100%, this suggests that environmental factors also play a role in the expression of OCD.

Adoption studies try to determine whether probands are more concordant with their adoptive or biological parents. These kinds of studies are extremely important in trying to disentangle the influence of biological and environmental factors. So far, there are no adoption studies published with OCD families.

Once it is determined that genetic factors play a role in a disorder, then the next step is to try to establish its mode of inheritance. Segregation analysis studies use statistical approaches to evaluate which would be the most probable inheritance pattern. They gather data on presence or absence of a disorder among family members and these data are analyzed to see if they fit with specific modes of inheritance. The OCD segregation analyses studies published so far revealed that the pattern within families is consistent with the hypothesis that OCD has a complex mode of inheritance, and that genes of major effect are probably involved in the transmission of OCD.

Association and linkage studies are the most common laboratory-based approaches used in the search for genes. Association studies compare the frequencies of a specific genetic marker or candidate gene among affected probands with the frequencies of the same marker among unaffected controls. If the marker occurs in significantly higher frequencies among the affected, then we can say that this marker is probably associated with the disease. Linkage studies look at the transmission of genetic markers within families, trying to identify possible chromosomal regions where a gene linked to a disorder would be located. Most of the candidate gene studies published so far have looked at markers in the serotonin and dopamine systems, COMT-L, GABA and MAO-A. Unfortunately, most of them have presented negative results; and the positive ones have not been replicated.

Despite all the progress, an OCD gene(s) has not been found so far. Nevertheless, this fact should not be regarded with pessimism since the studies have provided some important conclusions about the genetic mechanisms involved in OCD, such as, the fact that OCD does not follow a simple inheritance pattern and that the clinical presentation of the disorder (phenotype) is in fact very heterogeneous and most probably represents different underlying etiologic mechanisms.

Therefore, a lot of effort is being directed towards the identification of subgroups of OCD patients with good genetic validity. For instance, early-onset or tic-related OCD patients could represent highly genetic subgroups. Another promising approach is the evaluation of OC symptom dimensions, instead of symptom categories. Symptom dimensions can be used as quantitative phenotypes, which yield more power to genetic studies.

In order to pursue the goal of finding genes associated with OCD, we will need large numbers of OCD families, interviews designed to capture the multidimensionality of OC symptoms and colaboration efforts between researchers. At this point, we need more families to volunteer to participate in the genetics studies that are being done at various sites.*

Dr. Rosario-Campos is a post doctoral fellow at the Child Study Center at Yale University Medical Center.

* See the announcements about sites in the Bulletin Board.

Finch Program

(continued from page 3)

Do you make changes if a medication isn't working? What augmentation strategies do you follow?

DR. CALAMARI: The psychology department runs the program at Chicago Medical School; hence all medication management is referred to psychiatry.

NEWSLETTER: Can a person participate in your program if he or she doesn't want to take medication?

DR. CALAMARI: We have treated many people who choose not to take medication. We can support this choice if the person is able to successfully engage in ERP and concurrent depression is not severe. Many participants are able to do well without taking medication. In some cases, though, participants' reluctance to take medication is based on OCD related issues (e.g., contamination related beliefs). In such cases we encourage medication use not only to treat OCD symptoms but also as important step in ERP.

NEWSLETTER: How do you introduce a client to ERP and how do you help him acclimate to it?

DR. CALAMARI: Again, an important first step is to identify beliefs that are barriers to ERP (e.g., intense anxiety will cause me physical harm). Cognitive therapy and behavioral experiments will be used to help the participant evaluate these beliefs. We attempt to get these behavioral experiments underway during the lengthy evaluation process (e.g., an exposure exercise that brings on significant anxiety).

NEWSLETTER: How many treatment providers are involved in your OCD treatment program? What are their academic and professional backgrounds?

DR. CALAMARI: There are two doctoral level clinical psychologists who work in the program, Dr. John Burns, and myself. Dr. Burns has been treating OCD for five years and I have been doing this work for approximately 15 years. The program's therapists provide much of the ERP. They are advanced doctoral students in clinical psychology who work under our supervision. The program's therapists have completed didactic training on cognitive-behavioral therapy and initial clinical training before beginning their work at the Anxiety Clinic. Six to eight therapists work at the clinic at one time with each completing at least a year-long training rotation.

NEWSLETTER: What is your patient-to-staff ratio?

DR. CALAMARI: All of our treatment is provided in an individual therapy format. Participants in intensive treatment may have two therapists working with them to facilitate scheduling and home visits.

NEWSLETTER: What is a typical first day like in your program?

DR. CALAMARI: After completing a patient's assessment, which typically involves several initial meetings, ERP and cognitive therapy are initiated. Exposure exercises are focused on concerns that are expected to produce 50% of maximum anxiety or less. Activities practiced in session become homework. For some participants, initial sessions may be more focused on OCD-related beliefs, including some of the barriers to ERP previously described. Even in these cases, at least mild exposure work is attempted to challenge problematic beliefs.

NEWSLETTER: Can you describe a typical day in your program?

DR. CALAMARI: A typical session begins with a review of homework related successes or difficulties. Issues that proved difficult as homework will often be focused on in the session and appropriate ERP carried out. These sessions typically run about 90 minutes and parents or spouses will often attend at least part of the session. This is done to encourage family members to provide helpful at-home support for the ERP.

NEWSLETTER: Do patients in your program meet and work together over the course of the program?

DR. CALAMARI: All of our treatment is done on an individual basis. We do have an OCD support group that meets monthly and current and past program participants are encouraged to attend.

NEWSLETTER: Do you involve family members and significant others in your treatment program? How?

DR. CALAMARI: As mentioned, family members will often sit in during parts of the treatment and are encouraged, when appropriate, to provide at-home support. When relationships and family functioning is good, family members can provide valuable support. Families are provided basic information about OCD to encourage them to develop a more complete understanding of the disorder. In some cases, OCD will have helped to make family functioning so problematic that family members are minimally involved and emphasis is placed on the participant bringing the OCD under better control as a first step in improving family functioning.

NEWSLETTER: How do you handle OCD situations that are triggered only in a patient's home or place of work?

DR. CALAMARI: Oftentimes we can precipitate some approximation of those triggers at the clinic as a first step. Home visits are structured to help participants deal with these issues. Most often, work related issues can be approached only as homework.

NEWSLETTER: Do you handle the OC Spectrum Disorders, such as, body dysmorphic disorder and hypochondriasis, in your program also?

DR. CALAMARI: Yes, we treat OC spectrum disorders and other anxiety disorders (e.g., social phobia) that may occur with OCD.

NEWLSETTER: Will you allow a patient who has hoarding as his predominant symptom into this program?

DR. CALAMARI: We do treat people with hoarding problems. I have observed that family members more often refer these people and that they often do not do as well in treatment. We are hoping that some of the new developments in the conceptualization and treatment of hoarding will improve treatment outcome.

NEWSLETTER: OCD is a chronic illness, what kind of relapse prevention program do you provide?

DR. CALAMARI: We use several strategies to prevent relapse. First, we encourage program participants to address all aspects of their concerns during treatment rather than to just try to achieve significant symptom reduction. Confronting all aspects of the OCD reduces the possibility for relapse. Additionally, we use a traditional CBT relapse prevention approach. That is, we prepare the participant for symptom exacerbation during future stressful periods and rehearse management of these problems. Even individuals who have been highly successful in treatment are encouraged to come in for periodic booster sessions to get assistance in maintaining gains or in managing new symptoms that may have arisen.

NEWSLETTER: What determines a patient's initial and follow-up treatment schedule?

DR. CALAMARI: The frequency of initial and follow-up treatment is dependent on individual needs. We encourage all participants who have completed treatment to consider attending an OCD support group.

NEWSLETTER: Can patients with comorbid conditions or substance abuse problems be admitted to any of your OCD programs? Will they receive treatment for these co-occurring problems while in the intensive OCD program?

DR. CALAMARI: Many of the individuals we evaluate have several concurrent problems including substance abuse. The severity and nature of the current problems dictates what we might treat first or whether we might refer the individual to another program for initial treatment before ERP. For example, severe substance abuse will need to be brought under control before an individual can participate in ERP. Co-occurring problems are the rule, so we assess carefully for them and make treatment decisions based on the entire picture

NEWSLETTER: What kind of follow-up care do you provide for your program participants?

DR. CALAMARI: Follow-up treatment is individualized. We encourage intensive program participants to maintain contact with the program at least a couple of times per month for several months. Some participants, having com-

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pleted intensive treatment over ten years ago, still come in every few months for "booster" sessions.

NEWSLETTER: What is your success rate with OCD patients?

DR. CALAMARI: Approximately 80% of individuals who start treatment achieve significant symptom reduction. It has been my clinical observation that those who don't benefit are unable or unwilling to stop ritualizing.

NEWSLETTER: If someone is trying really hard, but has not progressed through the program in the allotted time, will you allow that person to continue on in the program?

DR. CALAMARI: We do not have a fixed time in mind for program completion, but carefully evaluate participants' progress. If participants are unable to do ERP consistently, we may shift emphasis to related beliefs and approach these beliefs while putting ERP on hold or at least slowing that aspect of the program. Individuals might also be referred for additional medication adjustment.

NEWSLETTER: Are there any research programs at your Clinic that OCD patients can participate in? What are they? How would someone sign up to participate?

DR. CALAMARI: At any given time there are several OCD research projects at the clinic. All program participants are asked to participate. Currently we have a treatment outcome study focused on OCD symptom subtypes underway that is funded by the OC Foundation. There are several studies focused on cognitive self-consciousness, the tendency to focus attention on one's thinking. We suspect that this construct may play an important role in the development and maintenance of OCD.

NEWSLETTER: Is your intensive treatment program covered by private insurance? Medicare? Medicaid?

DR. CALAMARI: Our intensive program is covered by private insurance, but not by Medicare or Medicaid.

NEWSLETTER: Does your Clinic have any programs to provide assistance to individuals who don't have the necessary financial resources to afford treatment?

DR. CALAMARI: At present we do not. We have made several attempts to obtain support from state agencies to fund such treatment but without success.

NEWSLETTER: If someone is interested in enrolling in your programs or wants more information about them, who should s/he contact and how?

DR. CALAMARI: Please contact me directly at 847-578-8747. I will be happy to provide information or have an assessment packet sent to the interested individual.

From the President

Dear Friends,

I'd like to give you an update on the OCF's research support activities. As you know, the Foundation awards grants each year to investigators committed to research into the causes and cures of OCD. The deadline for responding to our 2003 "Call for Proposals" was December 13. We have received 25 responses, the largest number since the OCF began this program.

This year in our "Call" we noted "Topics of Interest" for the Foundation. These are areas of inquiry that may lead to more effective treatment for everyone with OCD: basic neurobiology, the genetics of OCD, its epidemiology and etiology, and the treatment of the OC Spectrum Disorders.

In response we have received proposals that focus on genetic epidemiology of OCD, use of an augmenting drug for refractory OCD, analysis of response to antibiotic treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infection (PANDAS), neuroimaging, study of deep brain stimulation, investigation into treatment refusal, and the effectiveness of Exposure and Response Prevention. As you can see, this year's submissions are varied and all related to the Foundation's goal of "Effective Treatment for Everyone with OCD."

The next step for our potential grant recipients is a preliminary review of all of these proposals by the Review subcommittee of our Scientific Advisory Board. This year the subcommittee is again chaired by Lorrin M. Koran, M.D., professor of Psychiatry at Stanford University Medical Center and director of the Stanford OCD Clinic. The members of this year's subcommittee, all members of the OCF's Scientific Advisory Board, include John Griest, M.D., Co-Director and Distinguished Senior Scientist, Madison Institute of Medicine, Inc., Madison, WI; William Hewlett, M.D., Ph.D., director of the OCD/Tourette Program at Vanderbilt University Medical Center in Nashville, TN; Scott Rauch, M.D., director of Psychiatry Neuroimaging Research, Department of Psychiatry and Radiology, Harvard Medical School, Charlestown, MA; and Barbara Van Noppen, MSW, research associate, Department of Psychiatry, Brown University, Providence, RI.

After the preliminary review, investigators with qualified proposals will be asked to complete a more detailed application. These applications will be thoroughly reviewed and scored by the subcommittee members most familiar with the topic. During this process, the reviewers may communicate with the investigators to clarify information and discuss procedures. This review process can be very interactive with the members of the subcommittee volunteering their expertise and experience to help the investigators construct the best possible research project. Next, the entire subcommittee meets to discuss and score each proposal and then submits the proposals identified for funding to the OCF Board of Directors with the scores and the discussion notes.

The Board of Directors then votes to fund some or all of the proposals approved by the Review subcommittee. To a large extent, the board relies on the recommendations and information passed on to it by the Review subcommittee. The final determining factors are the degree to which each individual project furthers the research goals of the Foundation and the amount of money available to fund these projects.

In 2001, three projects were funded; in 2002, six studies received funding; this year we hope to award a greater number of grants. Because of your generosity, we think we are going to be able to do that. Since we launched the 2003 Research Fund campaign in December, 2002, until January 21, 2003, when we went to press, we raised $89,914.00 for research from 772 contributors. Answering Dr. Jenike's plea, donors made contributions from $1.00 to $20,000. The total requested this year to fund all the proposals that were submitted is $680,823.00. It appears from your response that we are all dedicated to the idea of promoting research to give everyone with OCD a chance for effective treatment.

Our affiliates and support groups were active in raising funds for research in 2002 as well. Our MetroChicago Affiliate gave $3,000 to the Foundation's Research Fund. This money was earmarked by the affiliate for a project begun in 2002 by Dr. John Calamari, a Chicago area researcher and clinician. It is the Chicago Affiliate's hope to stimulate more research in OCD among the area's investigators. Earlier in 2002, we received $1,000 from the Central New York affiliate for research, and $960.00 from the Long Island Support Group that was raised through its annual picnic.

On behalf of the board of directors of the Foundation, I want to thank everyone who contributed to the OCF Research Fund. We intend to formally thank each contributor in the Spring issue of the NEWSLETTER. Because of you, we are able to fund projects that will hopefully lead us to the discovery of more effective treatments for OCD.

Thank you,

Janet Emmerman
President
OCF Board of Directors

From the Foundation

Dear Friends,

We are beginning to plan for the second meeting of the OCD Genetics Consortium. It's going to take place March 22 and 23, 2003 at the OCD Clinic at Massachusetts General Hospital in Charlestown, MA. We're working on the agenda now. The group will have two days instead of just an afternoon; so there will be so much more that they can get accomplished.

We've sent out invitations and have heard back from almost everyone There are a few who have not officially RSVPed. But, what can you expect from genius scientists? Those who can't attend have promised to continue to recruit patients from their clinics and practices. This meeting will have investigators from Italy, Holland, Brazil, Israel, France, Mexico, South Africa, Germany, and Canada and all over the United States. Obviously, not too many of them are familiar with "Mud time", oops, I mean March in New England.

Since last summer, the group has not been idle. Not only are consortium members at their sites continuing to recruit families to particpate, but two of the groups have even submitted proposals on genetics studies for the 2003 OCF Research Awards. A governance committee and an assessment committee have formed. The members of the governance committee include: Dr. David Pauls and Dr. Gerald Nestadt, co-chairs, Joseph Zohar, M.D., Laura Bellodi, M.D., Michele Pato, M.D., and Karen Weissbecker, Ph.D.

And, the members of the assessment committee are: Drs. Pauls and Nestadt, co-chairs, James Leckman, M.D., Daniell Cath, M.D., Carol Matthews, M.D., Nadia Chabane, M.D., Euripedes Miguel, M.D., Abby Fyer, M.D., Steven Rasmussen, M.D. and Wayne Goodman, M.D.

These researchers need our help in their search for the gene or genes that cause OCD. The only way this research can be carried out is if families where one or more members have OCD symptoms volunteer to take part in these research studies. Families with OCD participating in these studies are not just important; they are absolutely essential to the research. No families; no genes.

In the Early Winter issue of the OCD Newsletter, I interviewed Dr. Gerald Nestadt, who heads the genetics group at Johns Hopkins University, about the importance of genetic studies for OCD and the need for families to participate in these ongoing genetics research programs. According to Dr. Nestadt, there are pragmatic, real world reasons to take part in genetic research that will impact every person and family that is affected by OCD. "Learning which genes are involved will lead to a greater understanding of how the disorder develops, and ultimately the development of rational treatments," observed Dr. Nestadt. "This knowledge will also enable us to identify individuals at risk for, or protected from OCD, and hence will encourage the development of preventive strategies," he added.

In describing the pivotal role of families in OCD genetics research, Dr. Nestadt said: "It is critical that we have a sufficient number of families participating to conduct this research." Families are the lynchpin of this work. Without them, investigators will not be able to develop a sufficient database and without a sufficient database, they will not be able to find the specific gene or genes involved in OCD. According to Dr. David Pauls, the co-chair of the Consortium, "(w)ith this knowledge, it will be easier to find effective treatments and learn more about how to prevent individuals at risk from developing OCD."

We are running the announcement for the centers participating in the NIH-funded collaborative study again in this issue of the NEWSLETTER. You'll find it on page 2 in the Bulletin Board. We've listed phone numbers and e-mails so you can call and volunteer. This research is also being done at the Yale Child Study Center. You can call Dr. Maria Rosario-Campos at (203) 785-6070 to find out more about participating in that study.

Last year, several of the research groups had booths at the OCD Annual Conference where families could sign up and be interviewed. We anticipate that these same centers will be recruiting families at this year's OCD Annual Conference. (This is just a little bit of advertising for the Conference. I am not above using any means to get people to come to the Annual Conference.)

We got the date. We've got the meeting place and we've invited the researchers who have agreed to be part of the OCD Genetics Consortium. Now, the long slow curve. We have to raise the funds to get them here, provide them with a warm, comfy place to sleep and some good food to keep them energized while they meet and discuss and make decisions. As I reread this, I have to admit that I'm beginning to sound more and more like the old monsignor at my childhood parish. Everyone identified him simply as "Monsignor Third Collection this Morning." I'm self-conscious about sticking my hand out, but unrepentant and shameless.

You were phenomenal last year when I asked for money for the first meeting of the Genetics Consortium. You were so generous that we had money leftover after paying all the expenses for the meeting. Unfortunately, not enough to underwrite the second meeting. We figure it is going to cost us approximately $35,000 for travel by plane, train and automobile for the 30 plus investigators who are planning on coming.

Last summer, the meeting took place on Sunday afternoon. We provided lunch and dinner for the participants. We also looked the other way if some of the investigators who got there early helped themselves to the Conference breakfast buffet. Unfortunately, we are going to have to provide a few more meals this time. They will probably want breakfast, lunch and dinner on Saturday and breakfast and lunch on Sunday. Some will arrive early and want dinner on Friday and some will stay for dinner on Sunday just because their flights aren't leaving until Monday. They'll probably also want a mid-afternoon snack just to keep up their strength. We anticipate a food and beverage bill of $6,825 if Dr. Jenike and the rest of the consortium members from Boston bring their own lunches and eat breakfast at home.

We gave them pads and pens last summer. I'm going to remind them all to bring them. If someone forgets his, he will need to use the snack napkins for taking notes.

We tried to get sleeping space at the OCD Institute in Belmont, MA to save a few bucks. Unfortunately, Dr. Jenike refused to give all his patients two-day passes and scoffed at our suggestion that we could get Medicare to underwrite their stay. So, despite my best efforts we are going to have to put the group up in a local hotel and transport them back and forth to the meeting. We anticipate the cost for that will be around $10,800, if the Boston-based group members return to their homes each night taking another member of the consortium with them.

So, once more without even blushing, I'm asking for your help. Please, think about how important the work of this group is to finding more effective treatments for OCD and slide a check into the envelope we've included in this issue of the Newsletter to make this meeting happen.

Ciao!

Patricia Perkins

Perspectives on Scrupulosity

(continued from page 1)

related to compulsions: the occurrence of an unwanted "bad" or "sinful" thought elicits feelings of anxiety, which in turn leads the scrupulous person to engage in anxiety-reducing activities. Some people might pray excessively, either outloud or silently. Others might feel a need to repeat religious rituals, such as crossing themselves. Still others might seek frequent reassurance from clergy or loved ones.

There is often a rigid or stereotyped quality to the behavior, which often must be repeated until it feels as if it has been done "just right." While these compulsions do tend to reduce the person's anxiety somewhat, they do so at a great price. When one tries to suppress an unwanted thought, the thought is experienced more frequently and intensely (Tolin, Abramowitz, Hamlin, Foa, & Synodi, 2002; Tolin, Abramowitz, Przeworski, & Foa, 2002). The compulsive behaviors also block the person from learning that disastrous consequences will not occur. Thus, the absence of disaster is interpreted as validation of the need for the compulsion.

I often find it helpful to have scrupulous clients talk to members of the clergy about their concerns. Well-informed clergy members can often do a much better job than I at discussing clients' concerns from a theological perspective. The idea for this article developed out of that practice. This article represents a "round table" discussion with three clergy members representing different religious traditions.

Father Joseph Donnelly is the pastor of a Roman Catholic parish of 2000 households in the Archdiocese of Hartford. Father Donnelly also works as a consultant and spiritual director with priests at the Institute of Living in Hartford, Connecticut. Reverend Melanie Enfield is an ordained minister in the United Church of Christ, a mainline Protestant denomination. Rev. Enfield is also Director of Pastoral Care at the Institute of Living, and works with patients on the inpatient and outpatient units. Philip Lazowski is a Conservative Jewish rabbi. Rabbi Lazowski also holds a Ph.D. in Jewish literature and consults at the Institute of Living. I am a clinical psychologist and director of the Anxiety Disorders Center at the Institute of Living. In this article, the four of us will discuss issues that are often raised in the context of scrupulosity treatment.

Dr. Tolin: What are some experiences you have had with people with scrupulosity?

Fr. Donnelly: Some scrupulous people see sin where there is no sin. This happens many times in confession. I have seen people returning to the confessional room minutes after finishing to report an offense they believe they "forgot" to confess. For example, people confess not attending Mass when they are sick, forgetting to say prayers, taking pleasure in a good meal or enjoying sexual intercourse.

Rabbi Lazowski: A member of my congregation would only pray when seated in "her" seat. She designated a particular seat as hers and even though there are close to one thousand other seats, she insisted on using that one. If someone else sat in "her" seat, she would ask him or her to move; and if that person refused, there would be a commotion during the service. That was her scrupulosity.

Fr. Donnelly: I spoke with a young man who was praying that his child would be healthy. He feared that he might leave out of his prayer a particular type of health, like the ability to see, hear, smell, walk, etc. His prayer became very specific, such as:"May the child be able to see, hear, speak, etc." I've also seen this in priests who were concerned that they say each word of the prayers of the Mass exactly as prescribed. They felt that if they didn't get the wording exactly right, the Mass would be invalid.

Dr. Tolin: This sounds like something I often see in clinical practice where people feel that there is a "just right" way to pray, so they need to pray over and over until the prayer is perfect. In many ways this seems related to the problem of pathological doubt where the person's brain keeps sending him the message that he has made an error of some kind, even if he hasn't.

Dr. Tolin: What are your general thoughts about scrupulosity?

Rev. Enfield: My first thought is that scrupulosity is a very difficult disorder. All mental illnesses are, yet this one poses a particular struggle for ministers. In many instances, we encourage people to pray, to live with moral integrity, and to lead a religious life. Yet for people with scrupulosity, our "normal" way of ministering could nurture their symptoms and do nothing to alleviate their suffering. So we need to work backwards, encouraging people to let go of their "scruples" in order for them to find a sense of peace and a sense of God's presence.

Fr. Donnelly: Some people might say that religion breeds scrupulosity. I would rather make the distinction that "unhealthy" religion breeds scrupulosity. The basic tenets of Christianity actually run counter to scrupulosity. For example, the belief in the loving and compassionate God that Jesus reveals can bring great peace to anyone who is honest and self-aware enough to acknowledge his or her sin. However, someone with an unhealthy and inaccurate sense of our faith could be encouraged to be scrupulous. Such people would perceive God as One who is constantly checking up on them and who is ready to condemn them for any sin they may commit. As a result, their lives lack peace. They are deprived of the assurance of God's love, which is assured as an essential component of Christian faith. I hold that all the great religions of the world express belief in a loving God. While this loving God expects that we live good, faithful and just lives, God understands and forgives those who sincerely recognize their sins and failings and try to be better. God always works for their good and takes no pleasure in "catching" anyone doing wrong.

Dr. Tolin: This raises the question: how do you define "doing wrong?" For example, one might get angry at another driver on the highway, and then worry that those angry feelings are sinful. How does your religion define a sin?

Rev. Enfield: Sin is that which separates us from God and neighbor. A part of being human is to be sinful. An aspect of our spirituality is to accept our humanness and our own imperfections. Becoming angry is a normal part of who we are. As we accept our humanness, we come to realize the amazing power of forgiveness and the amazing gift of God's grace. Forgiveness of sin is central to our religious beliefs.

Rabbi Lazowski: The most common terms for sin in Judaism are ***chayt*** and ***averah***. The first is usually translated as "sin" and the second as "transgression." Literally, however, ***chayt*** is a term from archery for missing the mark and ***averah*** means crossing over the line. In both cases, it seems to me, the implication is that one should try to overcome these shortcomings and improve oneself. Judaism also distinguishes between intentional sins and unintentional ones. In both cases, it is possible to seek forgiveness and to achieve atonement. Our annual High Holy Day season focuses on the possibility of atonement. "God does not desire the death of the sinner," our prayer book states, "but his return from his way that he may live."

Repentance, ***teshuvah***, is always available to the sinner. Our emphasis is on God's mercy and forgiveness. He is seen as waiting for us to return to Him. The Bible teaches us that there is no man on earth who does not sin. So, we have no expectation of perfection. One does the best one is capable of doing, but should be reassured that we have a forgiving God who is merciful with His human children.

Fr. Donnelly: The Catechism of the Catholic Church defines sin as "an offense against reason, truth and right conscience;

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it is a failure in genuine love of God and neighbor caused by a perverse attachment to certain goods.... an utterance, a deed or a desire contrary to the eternal law."

Dr. Tolin: What about intrusive thoughts that seem sinful or blasphemous to a person suffering from OCD? For example, I've met with people who will have the intrusive thought "I hate God" or a mental image of Jesus naked. Often, they believe that these occurrences indicate a moral or spiritual weakness. What does your religious teaching say about this?

Rabbi Lazowski: Our Jewish tradition has a long history of people challenging God and of holding Him to "higher" standards. Abraham confronts God over the decision to destroy Sodom and Gomorrah and demands: "Shall the judge of all the earth not do justly?" Moses also stands up to God on numerous occasions. In later history, some of the early figures of Hasidism, most notably Rabbi Levi Yitzhak of Berditchev, challenge God. There was a recent book published entitled "Arguing with God." We find statements implying that even one who denies God is not rejected. Our tradition believes that God is big enough to handle angry thoughts about him. Words are considered very powerful in Judaism, but there is greater concern about the words we use against people than those used against God. God can take abuse that people may not be able to withstand.

Rev. Enfield: Our religious teaching certainly does not encourage any form of blasphemy. Yet recurring intrusive thoughts are symptoms of a mental disorder and not a moral or spiritual weakness. The fact that a person is bothered by these thoughts is a sign that he or she does not really believe them and therefore is not showing irreverence to God. Rather, the intrusive thoughts indicate a need for psychological or emotional help.

Fr. Donnelly: Catholicism does not believe that thoughts in themselves can be sinful. The social sciences speak of a constant flow of thoughts in our minds. A thought can only become sinful when it fulfills the definition of sin that I mentioned earlier. For that to happen, the person needs to freely choose to nurture that thought (for example, thinking hateful or violent things about someone else).

Dr. Tolin: I think there is a consensus here that each of you sees blasphemous obsessions as fundamentally different from sinful thoughts. One potentially important distinction is that obsessions, even those that seem sacrilegious or horrible in some way, are viewed as intrusive mental activity over which the person has little control. I can see, though, how a scrupulous person might have difficulty with these definitions. For example, someone reading Rev. Enfield's comment might ask, "How do I know that I am really bothered by the thought?" Someone reading Fr. Donnelly's comment might ask, "How do I know that I didn't freely choose the thought?"

Fr. Donnelly: This could be a dilemma for the scrupulous person. I have had conversations with scrupulous people who grow more and more anxious trying to figure out whether or not they actually willed a "bad thought". And the more they attempt to rid themselves of the thought the more entrenched it seems to become.

Dr. Tolin: There is a body of research that demonstrates this principle: attempting to suppress an unwanted thought can prolong the thought and, in some cases, make the thought even worse. This seems to be particularly difficult for people who have OCD. It's as if the "off" switch in their brains doesn't work very well. But if I were suffering from scrupulosity, I think I would find it difficult to stop trying to suppress my thoughts, because the penalty for having such thoughts might be eternal damnation. What does your religious teaching suggest about this? Will people be punished for having horrible thoughts?

Rabbi Lazowski: Judaism clearly distinguishes between thoughts and deeds. One cannot be punished for one's thoughts, only for acting upon them.

Fr. Donnelly: Once again it is very important to start with what a person's image of God is. If it is a divine taskmaster or a harsh judge, then you can see how such an image might lead one to believe that God is out to punish such "bad thoughts." However, if we believe that God is a compassionate, loving parent, then we can grow to believe that God, who made us human, understands what the limits of humanness are and will be able to judge us fairly. As the Creator of the human person, God knows how we work even better than we know ourselves. Imagine how God understands the inner workings of mental illness!

Rev. Enfield: Our religious beliefs focus on a loving God and not one who condemns. God knows us better than we know ourselves. God understands us. It is my belief that from the beginning of time God has continually tried to reach out to people for redemption, to allow them to be in relationship with Him, rather than to be cut off from Him. I believe God has compassion on those who suffer from such uncomfortable thoughts.

Dr. Tolin: The general theme here is that God is compassionate and is unlikely to punish people as long as they are striving to improve their relationship with Him. This brings up the issue of prayer as a means to connect with God. Do you recommend that people say certain prayers in order to repent for bad thoughts, or to cancel them out?

Rev. Enfield: I would never want to underestimate the power of prayer. Through prayer, we can certainly experience healing and forgiveness. Yet, God doesn't keep score. We receive forgiveness, not by our own merit, but through the grace of God. Our religious teaching would not recommend saying certain prayers to cancel out a particular sin.

Fr. Donnelly: In the Catholic tradition there have been times in history when people, even religious leaders, have advertised a prayer that absolutely does this or that. "Say this prayer and all your sins will be forgiven." Such assurances represent an inaccurate and unhealthy attitude about prayer. St. Thomas Aquinas said: "Prayer renders us capable of receiving." Prayer, in other words, opens us to God and as such can help us to better follow God's way. When one is genuinely plagued by bad thoughts, prayer can be helpful in focusing us on God and in showing us how to do what God desires. In this way, a chosen prayer may help us to think of other things and it may help to remove the anxiety that comes from such thoughts. But there is no sure-fire prayer that will do that in itself.

Rabbi Lazowski: Admittedly there is a ritual for reversing a bad dream (most people do not even know about this ritual that appears in very traditional prayer books), but I don't know of prayers to cancel out bad thoughts. The closest we come to that are bedtime prayers which ask: "Let my sleep be undisturbed by troubling thoughts, bad dreams and wicked schemes." In the Yom Kippur liturgy, one also finds prayers asking for forgiveness for any sins committed before God "by sinful thoughts."

Dr. Tolin: So there is some rationale for prayer related to troublesome thoughts, although I think it is different from how scrupulous people often use prayer. Is it possible to overdo it with prayer? Does one need to do a perfect job, or say a prayer over and over again until it feels "just right?" How closely does one need to follow the rules of her religion?

Rev. Enfield: Our denomination does not focus on certain laws or prayers of the church. We don't have many absolutes in our church; rather, we encourage people to deepen their faith through study, worship or acts of service. We acknowledge our imperfections as a reason we need

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God in our lives. We can't do it on our own; we are not perfect, yet God still loves us. We are saved by faith.

Rabbi Lazowski: Within Judaism, there is a wide range of behaviors. Taking the dietary laws as an example, there are basic laws from the bible and rabbinic laws that expand upon them, plus a number of additional restrictions observed by certain groups and individuals. Generally, an individual will decide the level of observance to which he/she will adhere. As mentioned earlier, if one violates the law unintentionally, one can seek forgiveness for the transgression. It is not an irrevocable tragedy. One might legitimately feel upset or angry about the inadvertent violation of one's standards of observance, but it is not the end of the world. One who intentionally violates the law has, indeed, committed a sin. But with all sins, one can seek forgiveness and return to God by regretting the past, asking for forgiveness, and changing one's ways in the future.

Fr. Donnelly: I love the quotation attributed to Mother Theresa of Calcutta: "God does not asks us to be perfect; God asks us to be faithful." That says it all. Faithfulness is an attribute of a relationship based upon love. Perfection seems to be more part of a list of expectations one demands of another over whom one has authority. Loving relationships are more than a list of what the other expects me to do. I encourage people to strive to be faithful to the relationship they have with the God who loves them. Using the image of a spousal relationship or the relationship of parent and child can be helpful here. Mistakes can be made in either relationship. Times of hard conversations and mutual disappointment happen. But real love is stronger than that. People striving to be faithful grow in their relationships and in their love for the other. Striving to live a faithful religious life is a process that can lead to a similar end. Religious tasks are meant to facilitate a good loving relationship with God and others and to help us live good moral lives. They are not ends in themselves and doing them "perfectly" is not our life's goal.

Dr. Tolin: Let's talk about the treatment of scrupulosity for a moment. One of the things we know about OCD, which is echoed in Fr. Donnelly's comment, is that when someone is bothered by an intrusive thought, especially if he believes the stakes to be high, he tends to want to suppress it or banish it from his mind. Unfortunately, as we know from psychology research, these attempts typically make the person think about it even more. So trying not to think "I hate God" in church paradoxically increases the likelihood that these words will come into one's mind. In exposure-based therapy, that person might be encouraged to think these words over and over again on purpose during the church service until it stops bothering her. Or a person who is bothered by mental images of Jesus naked might be instructed to think about this on purpose over and over again, without saying prayers to "undo" it, until he is no longer bothered by it. However, scrupulous people often have difficulty accepting this kind of treatment. They believe that by doing these things on purpose, they are committing a very sinful act and will be punished. How would the clergy of your religion view this kind of treatment?

Rev. Enfield: Clergy would not want this to be the norm of behavior, yet would want to be supportive of the treatment that a person was undertaking. As clergy gain a greater understanding of the severity of the problem, it is my belief that most would do what they could to help. I don't believe that this form of treatment is a sinful act because the goal of treatment is to liberate the person from the thoughts that are so confining and painful. My belief is that God is life giving. As people are liberated from their "scruples," they are then free to grow and become who God created them to be.

Rabbi Lazowski: Judaism is committed to healing of body and soul. A legitimate therapy, which involves a transgression of the law, might well be permitted in order to heal the ailing soul. For example, one may not erase the Divine name, yet to make peace between husband and wife, a parchment scroll containing God's name is immersed in water and erased and the concoction is given to the suspected wife to drink in order to clear her from suspicion of adultery in her husband's eyes. In general, Judaism teaches "you shall live by them (the commandments) and not die by them." In order to preserve life, one may violate any commandment except those prohibiting murder, idolatry and sexual immorality.

Fr. Donnelly: I believe that Catholicism would support such treatment for this mental illness. Obviously, the use of such treatment has as its end the mental health of the patient and not the encouragement of blasphemous behavior. That distinction would have to be made clear to the patient. We believe that God wants us to be healthy mature people and any treatment that can facilitate that well-being is acceptable.

This panel discussion has presented theological perspectives from three major religious traditions.* While there are obviously some very important ideological differences among these perspectives, I am more struck by the similarities. Each of our panelists recognizes scrupulosity as a unique disorder that compromises one's genuine religious functioning. We also see a general sentiment that blasphemous or sacrilegious obsessions are not seen as sinful; rather, these clergy members recognize such obsessions as signs of a psychological disorder. All three have emphasized the view of God as forgiving figure rather than a punishing one. There seems to be a consensus that God does not operate in the manner that many scrupulous individuals believe (and fear). Specifically, God is seen as possessing a clear understanding of OCD and its symptoms, and is more likely to be compassionate about the person's pain than angry at the content of his thoughts. None of our panelists sees a role for the compulsive "neutralizing" prayers and rituals that are so common in scrupulosity.

It is particularly interesting that the idea of exposure therapy seems quite acceptable to these clergy members. Readers of this newsletter are no doubt aware that cognitive-behavioral therapy incorporating exposure and ritual prevention is an efficacious treatment for OCD (e.g., Kozak, Liebowitz, & Foa, 2000). While the specific efficacy of this treatment for scrupulous OCD has not been evaluated systematically, clinical experience suggests that instructing people to commit religious "infractions," such as, saying a prayer wrong or deliberately thinking "forbidden" thoughts, while simultaneously refraining from praying or otherwise "neutralizing," can be a powerful and effective intervention. This panel discussion suggests that such treatment is tolerated by clergy. They understand that exposure exercises are designed not to offend God but rather to help the sufferer get better. Some have even noted that, when one is freed from obsessions, s/he actually has more room for God in his/her life. This rings true with my clinical experience – rather than deepening one's appreciation for God and religion, scrupulosity seems all too often to create barriers to a genuine spiritual life. Breaking free of scrupulosity, therefore, may allow the person to participate more fully and authentically in his/her faith and to begin to develop a healthy relationship with God.

I would like to thank Dr. Scott Hannan for his assistance with the preparation of this manuscript. (DT)

**We acknowledge that we did not include clergy from all religions. However, we invite clergy representing these other faiths to enter into this discussion by sending letters for publication to the editor of the OCD NEWSLETTER.*

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OCD and Depression

The Mayo Clinic OCD/Anxiety Disorders Program is seeking adults with OCD who are also depressed to participate in a treatment study. The purpose of this research is to examine the effectiveness of a comprehensive CBT program that addresses both depressive and OCD symptoms simultaneously. Participants will undergo a 16-session (twice-weekly sessions for 8 weeks) treatment program and receive follow-up assessments. Participants will be partially reimbursed for their participation.
Who is eligible to participate? If you are between the ages of 18 and 70 and suffer from OCD along with depression you may be eligible. You also must be able to attend 16 sessions over 8 weeks at Mayo Clinic in Rochester, MN.
Benefits for participants: You may not receive any direct benefits from participating. However, it is possible that your OCD and depressive symptoms may improve from the CBT you'll receive. There is good evidence that CBT is helpful for both OCD and depression.
Contact information: The study is being conducted by Jon Abramowitz, Ph.D., and colleagues. Further information is available by contacting Dr. Abramowitz at 507-284-4431, or via e-mail: abramowitz.jonathan@mayo.edu. This study has IRB approval and is being funded by the OC Foundation.

OCD Neuroimaging Study

The Mayo Clinic OCD/Anxiety Disorders Program is seeking adults with OCD for a study on the effects of cognitive-behavior therapy on brain functioning. Eligible participants will receive 16 treatment sessions over 8 weeks (twice-weekly) and have "pictures" of their brain taken with an MRI scan before the first treatment session and following the last (16th session). Participants will also receive compensation for their participation.
Who is eligible to participate? If you are between the ages of 18 and 70 and suffer from OCD you may be eligible. You also must be able to attend 16 sessions over 8 weeks at Mayo Clinic in Rochester, MN.
Benefits for participants: You may not receive any direct benefits from participating. However, it is possible that your OCD and depressive symptoms may improve from the CBT you'll receive. There is good evidence that CBT is helpful for OCD. You can also obtain a "picture" of your brain from the MRI scan.
Further information is available by contacting Dr. Whiteside at 507-284-4431, or via e-mail: whiteside.stephen@mayo.edu. This study has IRB approval and is being funded by the OC Foundation.

Genetics and OCD

The Mayo Clinic OCD/Anxiety Disorders Program is seeking adults who have received successful or unsuccessful medication treatments for OCD. The purpose of this research is to examine the genetics of treatment response to serotonin medication in patients with OCD. It may be possible to use genetic screening to predict who will respond to these kinds of medicines and who will experience side effects or no improvement. Participants will undergo a clinical evaluation, blood draw, and urine screen and be reimbursed for their participation.
Who is eligible to participate? If you are between the ages of 18 and 65 and have received serotonin reuptake medication for OCD (these medications include: Anafranil, Zoloft, Paxil, Celexa, Prozac, Luvox, among others) you may be eligible. Participants must also be able to commute to Mayo Clinic in Rochester, MN.
Further information is available by contacting Dr. Schwartz at 507-284-4431, or via e-mail: schwartz.stefanie@mayo.edu. This study has IRB approval and is funded by the OC Foundation.

University of California Los Angeles (UCLA) is conducting a number of studies on Obsessive Compulsive Disorder. Participants should be able to come to UCLA regularly for appointments.

PET/PAXIL STUDY

This is a 12-week study for people with Obsessive Compulsive Disorder who are not taking medication. This study is researching changes in brain glucose metabolism of people with OCD treated with the medication Paxil.
For the participant, this study involves having a PET scan of the brain prior to commencing a 12-week regimen of Paxil and then a second PET scan at the end of the regimen. It also involves having an MRI scan of the brain. Participants will be closely monitored for side effects and efficacy of the medications by their study doctor. For more information on this study please call (310) 794-7305.

PET/PAXIL HOARDING STUDY

This is a 12-week study for people with Obsessive Compulsive Disorder, and more specifically those people who have the hoarding/packrat/clutter syndrome who are between the ages of 18-65 years. This study is researching changes in brain glucose metabolism in people with hoarding as a problem.
For the participant, this study involves a PET scan of the brain prior to commencing a 12-week regimen of Paxil and then a second PET scan at the end of the regimen. It also involves having an MRI scan of the brain. Participants will be closely monitored for side effects and efficacy of the medications by their study doctor. For more information on this study please call (310) 794-7305.

PET/CBT/NEUROCOGNITIVE TESTING STUDY

This 4-week study for people with Obsessive Compulsive Disorder involves having a PET scan of the brain and a 2-hour battery of neurocognitive tests prior to 4 weeks of intensive Cognitive Behavior Therapy (CBT). Participants will also have an MRI of the brain during the 4 week treatment phase. CBT involves daily (Mon-Fri), 90-minute sessions with a therapist. Participants will receive a second PET scan of the brain and a shortened battery of neurocognitive tests at the end of treatment.
This study is looking at changes in brain metabolism before and after treatment with CBT. It is also looking at changes in neurocognitive functioning before and after treatment.
For more information on this study please call (310) 794-7305.

SEROQUEL AUGMENTATION STUDY

This is a 10-week study for people with Obsessive Compulsive Disorder who have tried standard Serotonin Reuptake Inhibitor (SRI) treatment for their OCD but found little or no relief of their symptoms. The effects of an SRI medication may be enhanced with the addition of Seroquel, an atypical antipsychotic medication. This study is for people who are currently taking an SRI medication for OCD, but find that it is not providing adequate relief of symptoms.
For more information on this study please call (310) 794-1038.

Multi-Center Trial of Ziprasidone (Geodon) Augmentation in Serotonin Reuptake Inhibitor-Resistant Obsessive-Compulsive Disorder (OCD)

The purpose of this research is to obtain data or information on the safety and effectiveness of ziprasidone (Geodon), for the treatment of obsessive-compulsive disorder (OCD) in patients who have not had a satisfactory response to an adequate trial of at least one anti-OCD medication (a serotonin reuptake inhibitor [SRI]). Ziprasidone has been approved by the federal Food and Drug Administration (FDA) as safe and effective for the treatment of schizophrenia. We have decided to do this study because a medication called risperidone, which has actions similar to those of ziprasidone, has been found effective in relieving the symptoms of OCD in patients whose symptoms have not responded to an SRI alone.
Patients eligible to participate in this double-blind study are randomly assigned to receive augmentation of their SRI treatment with either ziprasidone or placebo (an inactive substance

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that provides no medical treatment) for 8 weeks. There will be a maximum of 8 visits in total. Each visit should last about an hour, except for the pre-study and final visits, which will last approximately 4 hours and will involve the following procedures: an extended interview by a psychiatrist to document your symptoms (every visit), a complete physical examination by a doctor of internal medicine, an EKG, and a blood sample will be drawn.
To be eligible, patients must be between the ages of 18 and 65, have OCD as their primary diagnosis, have obtained an unsatisfactory or no response from at least one, and up to three adequate SRI trials (Serotonin Reuptake Inhibitors: Anafranil, Effexor, Celexa, Luvox, Paxil, Prozac, and Zoloft), and agree to continue on their current SRI medication. Additional eligibility requirements will be reviewed with each patient during a detailed phone screening.
For more information, please contact:
Helen Chuong, Clinical Research Coordinator
(650) 498-5644, email: helenc@stanford.edu
or visit our web site: http://ocd.stanford.edu
Stanford University Medical Center
Department of Psychiatry/OCD
401 Quarry Rd.
Stanford, CA 94305-5721

Obsessive-Compulsive Disorder Study

Are you bothered by repetitive thoughts that you cannot control? Are you unable to resist doing some activity over and over? Are these thoughts or behaviors interfering with your daily life?
The Mood and Anxiety Disorders Program of Emory University is conducting a research study for people diagnosed with Obsessive-Compulsive Disorder (OCD) and on medication. This study will test the effectiveness of an additional medication to obtain further benefits in treating OCD.
Participants must be at least 18 years old and in stable medical condition. A psychiatric evaluation, study medication, a physical exam, and laboratory tests are provided at no cost. Participation will last up to 8 weeks. The clinic visits will take place at Wesley Woods Health Center, 1841 Clifton Road, Atlanta, GA
All involvement is confidential.
For more information, please call:
404-712-MOOD
or visit: www.emoryclinicaltrials.com

Still Having Obsessions or Compulsions? Not Satisfied with your Medication?

The University of Florida Department of Psychiatry is conducting a study on adding a research medication to certain medications used for treating Obsessive-Compulsive Disorder (OCD), such as, Prozac, Paxil, Zoloft, Celexa, or Luvox.
To be eligible, you must be 18 to 65 years old and in general good health. The study includes: office visits, medical exams, laboratory tests, psychiatric evaluations, and study medication. If interested, please call our referral line toll-free at 877-788-3994 or e-mail us at clintrls@psych.med.ufl.edu

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:
Victoria Stein
The New York State Psychiatric Institute
Unit 74, Rm 2301
1051 Riverside Drive
New York, NY 10032
(212) 543-6287
steinv@child.cpmc.columbia.edu
Note: The study will be conducted at the Yale Child Study Center in New Haven, CT, not at NYSPI.

Free Inpatient/Outpatient Study at Yale

The Yale Clinical Neuroscience Research Unit in New Haven, Connecticut has received approval for a six-week medication study for patients with obsessive-compulsive disorder. Individuals with a primary diagnosis of OCD who are currently taking a serotonin-reuptake inhibitor (SSRI) and are still experiencing distressing OCD symptoms may be eligible. Patients will remain on their SSRI and the study medication will be added.
All treatment on the Clinical Neuroscience Research Unit is free of charge – we do not go through insurance. For a free confidential telephone screening to determine eligibility, please call Suzanne Wayslink, R.N.C., at (203) 974-7523. Principal Investigator: Vladimir Coric, M.D. (203) 974 7522. (Yale-HIC# 15638)

CBT Research Study at Harvard

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

* a clinical evaluation, at no cost
* 18 to 22 sessions of cognitive therapy, at no cost

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

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

Announcing Spring 2003 Trichotillomania Event

Rosemont Counseling Associates, Rosemont Counseling Adult Trichotillomania Support Groups and the Philadelphia Affiliate of the National Obsessive Compulsive Foundation are pleased to announce the Spring Program for Children and Adults with Trichotillomania and Their Significant Others. All Trich sufferers, family members and significant others are invited to join the Rosemont Counseling staff and the Adult Trichotillomania Support Group for this informative and therapeutic half-day program.

Program activities will include: discussion of medications and treatment, sharing of Trich stories, special sessions for children, adults and significant others, ending with Trich success stories.

When: Saturday, March 29, 2003 9:30-1:30 (Continental breakfast and light refreshments will be served.)

Where: Rosemont Plaza
1062 Lancaster Avenue
Rosemont, PA 19010

Rosemont Counseling Associates staff facilitating the program include: Sally Allen, M.S.Ed.; Judith Kolman, Ph.D.; Elizabeth Fallon, M.S., R.N., C.S.; and B. Kenneth Nelson, M.D.

For more information or to register for this program, please contact Sally Allen, Clinical Director of Rosemont Counseling at (610) 525-1510.

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