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OCD Treatment: Fighting Back *

By Laurie Krauth, MA, LLP
Ann Arbor, Michigan

A young executive can't wear clothes until they are put on "just right." He loses his job because it takes him so many hours to get dressed.

A new mother is terrified that her blasphemous thoughts will kill her infant. So she stands over his crib repeating, "I love you Jesus" six times. If she's distracted by a thought of the Devil or the sound of a passing car outside, she starts again. And again.

A football coach is afraid that his favorite aunt will die in a car crash if he does something wrong – but "wrong" keeps changing so he has to stay on his toes. One day "wrong" means thinking of her as he puts on his favorite jersey; the next day it means picking up a box of cereal at the grocery store with an "expires by" date that adds up to his aunt's birthday.

No wonder obsessive compulsive disorder is called the "doubting disease." Your obsessive thoughts cause your anxiety to soar. You try to calm yourself by doing rituals that make no sense to you intellectually. Still you shudder at the thought that if you don't do what the OCD is telling you to do, something will go wrong – someone you love will be hurt, your day will be ruined. There will be dire consequences to someone, somewhere.

No matter how smart, logical, or compassionate you are, you are blackmailed by the thought, however irrational, that the OCD may be telling the truth and the stakes are too high to ignore it.

"My house could burn down if I don't check the burners and knobs on the stove for half an hour," you think to yourself. "Really, how can I resist the time and effort involved in my rituals if there's the

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"The Aviator" – Howard Hughes vs. OCD

By Fred Penzel, Ph.D.
Executive Director
Western Suffolk Psychological Services
Huntington, New York

As I left to see The Aviator last night, I must admit that I wasn't expecting much. I tend to find films dealing with OCD somewhat disappointing and occasionally infuriating. I might find some of them funny, if they did not contribute to the face of OCD that is presented to the world at large. The coming attractions I had seen weren't all that promising either. They showed the multimillionaire Howard Hughes furiously washing his hands bent over a sink. "Oh no," I thought, "not another insult to the intelligence via a new batch of old OCD cliches."

Although I do not suffer from OCD, I spend an average of forty hours each week helping people who do. After having done this regularly since 1982, I think it safe to say that I have a pretty good sense of what OCD is all about. I don't have a lot of patience for mediocre movies in general, and even less for those that are just plain inaccurate, or that twist the truth beyond all recognition. I particularly don't have much patience for films that portray OCD sufferers as foolish eccentrics, crazed stalkers, or raving lunatics.

The opening scene only seemed to confirm my worst fears. One of my old film professors from my theatre school days always stressed the importance of a film's opening shot and first scene because they set the

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A Message From the President

Here I sit looking out the window. The snow has temporarily disappeared, and for a moment, I can imagine spring just around the corner. Of course, that is just wishful thinking on my part. In New England, the winters can last through April. I guess we will have to wait to see what Mother Nature has planned for us in the next few months.

One thing I do know is that there are many good things that will be happening for the OC Foundation in the New Year. It is with pleasure that I share them with you.

The proposals for the 2005 Research Grants have arrived at OCF headquarters in Connecticut. A review committee will be set up shortly. After that the 42 proposals that have been submitted will be reviewed and evaluated. We should be able to annouce the winners in late spring.

As you all know, a few years ago, we set up the OCF Genetics Collaborative that consists of investigators from around the world. These investigators share their research with one another in hopes of discovering the genetic links to OCD. Later this year, the group will meet once again in Boston to update one another

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Sign Up for the Philly BTI – April 29 to May 1, 2005

Bulletin Board

BDD Conference

The First Body Dysmorphic Disorder Conference in North America!

To be held on Saturday, April 23, 2005 from 8:00 am to 5:30 pm at:

UCLA Neuropsychiatric Institute
Auditorium
760 Westwood Plaza
Los Angeles, California 90024

Speakers include:

Katharine Phillips, M.D.
Sabine Wilhelm, Ph.D.
Fugen Neziroglu, Ph.D.
Jim Claiborn, Ph.D.
Arie Winograd, M.A., L.M.F.T.
Jamie Feusner, M.D.
Scott Granet, L.C.S.W.
Sanjaya Saxena, M.D.

This first-of-its-kind conference will be a whole day event and will cover many aspects of BDD including neurobiology, neurocognition, psychotherapy, and pharmacotherapy. In addition, coping strategies for families and resources for support will also be addressed. The conference is directed at psychiatrists, psychotherapists, dermatologists, cosmetic surgeons, and BDD sufferers and their families. Continuing education credits will be available.

The cost of the conference is $130 for professionals, and $50 for patients, family members, and concerned others. All proceeds from the conference will go to the Neysa Jane BDD Fund, Inc. to further BDD research and education.

For more information, contact Scott Granet at (650) 599-3325 or Arie Winograd at Director@AccurateReflections.com or visit: www.accuratereflections.com/BDDconference.html.

Internet-Based OCD Behavioral Assessment Research Study

Is OCD interfering in your life?

If you have been diagnosed with OCD, are 18 years of age or older, and have access to either a personal or a public computer connected to the Internet, you are eligible to participate in an anonymous research study to investigate the use of a Web site to help assess the symptoms of OCD and to help design a behavior therapy practice assignment.

The study will require you to spend about 30 minutes interacting with an investigational Web site and answering questions about your OCD symptoms. No information will be recorded that would permit you to be identified.

To participate in this study, use your computer's browser to go to: www.btsteps.com

Lee Baer, Ph.D.
William E. Minichiello, Ed.D.
Department of Psychiatry, Massachusetts General Hospital
Boston, MA
Telephone: 617-726-4072

Does your child or teenager take medication for OCD?

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

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

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

Children ages 7-17 with a diagnosis of OCD, who are taking fluoxetine (Prozac), sertaline (Zoloft), or fluvoxamine (Luvox), and who still have residual OCD symptoms may be eligible. Children taking citalopram (Celexa) or escitalopram (Lexapro) may also be eligible.

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

Contact information:

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

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

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

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OCD NEWSLETTER

The OCD Newsletter is published six times a year.

Obsessive Compulsive Foundation, Inc.
Phone: (203) 401-2070
Fax: (203) 401-2076
e-mail: info@ocfoundation.org
web site: www.ocfoundation.org
Joy Kant, 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. Its mission is to increase research into, treatment for and understanding of Obsessive Compulsive Disorder (OCD). In addition to its bimonthly newsletter, OCF resources and activities include: an annual membership conference; popular Web site; training programs for mental health professionals; annual research awards; affiliates and support groups throughout the United States and Canada; referrals to treatment providers; and the distribution of books, videos, and other OCD-related materials through the OCF bookstore; and other programs.

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

How I Treat OCD – A Forum

In this feature, mental health professionals discuss their view and theories on treating OCD and the OC Spectrum disorders. To submit an article for this feature, call Patricia Perkins at 203-401-2074.

Understanding the Neurology of OCD and "Emotional Hallucinations"

By Bruce Mansbridge, Ph.D.
Director, Austin Center for the Treatment of OCD
Austin, Texas

The bulk of my treatment for OCD follows the fairly standard cognitive-behavioral treatment of exposure and ritual prevention (ERP), which I will not go into in depth here. The primary way in which my treatment may differ from that of others is in the initial preparation of the patient for the actual therapy. Also, I prefer to start patients off with very mild exposures, and I do not insist that they experience significant anxiety at first.

Because ERP requires patients to do the very things they dread doing, it is crucial that they understand what OCD is and is not, how and why ERP works, and be motivated to do it. They also need to be reassured that I will never make them do anything. I emphasize that we are a team. I am the coach, with expertise in treating OCD. The patient is the quarterback, calling the plays and setting the goals.

First, I explain that OCD is a neurobiological disorder. It is both more accurate and more helpful to see it as a neurological problem than a psychological one. We know that the frontal cortex, the decision-making (or "executive") part of the brain, is involved in OCD, as are the striatum (which can be seen as kind of an "executive secretary") and the thalamus. We believe that this circuit is overactive in OCD, and when the OCD is successfully treated – either with medication or behavior therapy – this circuit is calmed down.

I start by showing some optical illusions as examples of how our frontal cortex can be fooled. I point out that while sensation occurs at the level of the sensory organ (for example, the retina), perception (making sense out of the input) occurs in the cortex, which can access previous experiences and analytical skills. Often, in optical illusions, our previous experience can be used to fool us. Over time, our brains become so experienced and talented at correcting for shadows, distance, or perspective, that these corrections become so automatic that we find it difficult, if not impossible, not to make these corrections.

For example, in Figure 1, the tabletops are exactly the same size and shape. Our frontal cortex is fooled, however, because it assumes these drawings are in perspective. This correcting for depth is so automatic that when we see our friend across the street, we don't think, "Oh my gosh, what's happened to Jim? He's only two inches tall! Oh, wait a sec – it's OK, he's across the street." We're so used to compensating for depth every second our eyes are open that it occurs without thinking or even awareness.

In Figure 1, these two tabletops are actually identical in size and shape, but because our brains are so used to correcting for perspective, they appear to be different. (You can trace the shapes to verify that they are the same.)

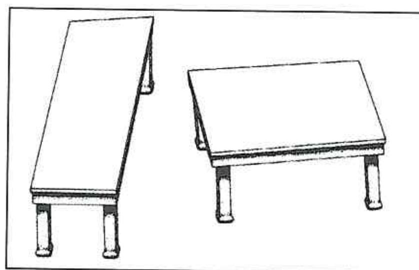

Figure 1

In Figure 2, the checkerboard square in the shadow is the same shade of gray as the seemingly darker squares outside the shadow. The shadow of the cylinder darkens the square, but we can't help compensating for the shadow, so we perceive it as lighter than it really is. Photographers learn to pay attention to shadows, because they know that they may be more prominent when they show up in the final shot.

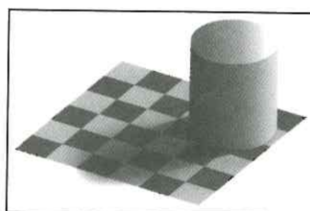

Figure 2

Also in Figure 2, the "light" square in the center of the shadow is actually the same shade of gray as the "dark" squares outside the shadow. Our frontal cortex compensates automatically for shadows just as it compensates for distance in coming up with its best guess as to what is really out there.

Figure 3 can be used to demonstrate the "blind spot" in each of our eyes. The retina at the back of the eye is like a curved screen, lined with light receptors called rods and cones on which images that pass through the eye are focused. But there are no rods or cones at the spot where the optic nerve leaves the retina. It's a little like the drain in a bathtub. It's all porcelain except for the drain. When an image or part of an image falls on this spot, no receptors are triggered, because they're not there. What is remarkable is that our brain "fills in" what it reasonably expects to be there; so if we close one eye and look around the room, we don't see a blank or gray spot in our field of vision.

Find your blind spot and trick your cortex into seeing something that isn't there. In Figure 3 cover your right eye and stare at the tiny black dot in the center of the large cross on the right. You can see the smaller cross to the left, but don't look

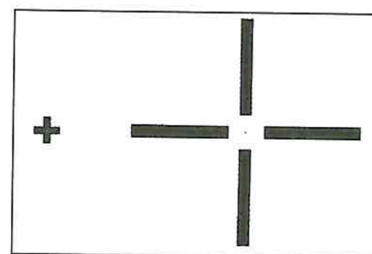

Figure 3

directly at it. Keep your eye on the dot and slowly move the page in and out. At some point, the smaller cross will disappear. This is the point at which the image of the smaller cross is landing on a part of your retina that has no light receptors. You are not seeing something that is really there. Now turn the page upside down. Again, with your right eye covered, stare at the tiny white dot at the center of the smaller cross. Again, slowly move the page in and out until the center of the larger cross falls on your blind spot. Instead of something disappearing, you will see the center of the cross fill in! Now you are seeing something that really is not there. Although this is perfectly normal, you have just experienced a positive hallucination.

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How I Treat OCD

Understanding the Neurology of OCD

(continued from page 3)

According to the accepted definition of a hallucination (the perception of sensory experiences without an external stimulus and with a compelling sense of their reality), seeing something that isn't really there is called a positive hallucination. Seeing the cross fill in with the content of what is seen being generated entirely from our own brain fits this definition perfectly.

While optical illusions are easy to demonstrate, they are far removed from the phenomena experienced in OCD. A closer example is the phenomenon known as deja vu (French for "already seen"). True deja vu is the experience of having seen or experienced something before when one actually has not. It is to be distinguished from the experience of recognizing that one has seen something before but not remembering where, which some have incorrectly labeled deja vu.

The most cogent explanation of deja vu is a neurological one: There is enormous redundancy built into the human neurological system, especially the sensory input system. We don't depend on a single pathway for input to reach our brains. Ordinarily, when we walk into a room, millions of signals from the eyes rush to our brain. Since our brain is so close to our eyes, the signals usually arrive pretty much all at the same time.

But these nerves are actually a network, not unlike a network of roads. Just as there are many ways to drive from one place to another, some longer than others, there are millions of different routes that these messages can take to reach the brain. Not all of the messages arrive at exactly the same time. Occasionally, one impulse or message can take the "long way round" and arrive a split second after the others. When it arrives, it's compared with what's already in memory (as are all inputs routinely); and lo and behold, there's a match – it's already there!

The executive part of the brain basically receives a report that this event, known by most of the rational brain to be a new event, has definitely been experienced previously. It's a strange experience! The fact that deja vu is mostly experienced in childhood and young adulthood suggests that it may be partly due to a somewhat immature nervous system. (Just as we're less likely to take the long way round after we've been driving in a particular area for a while.) This type of neurological glitch probably occurs in other sensory systems as well, but delays of a millisecond are not detected in smell, taste, touch or hearing.

Another example of a neurological glitch, one that more closely resembles the glitch in OCD, is the phenomenon called phantom limb pain, in which an amputee feels pain in a part of the body that is no longer there. For example, someone whose arm has been amputated may feel that his thumb is being crushed. It can be a very specific pain, e.g., that the top or the sides of the thumb are being crushed. To oversimplify, it is as though the nerves that once were used to deliver such a message are being stimulated, and the message gets sent to the frontal cortex. There is nothing counterfeit about the pain: It is 100% real. The difference is that the signal is not coming from the thumb but from the nerves that used to be connected to the thumb.

I have demonstrated the following hypnotic phenomenon many times. After hypnotizing someone, I would give him a posthypnotic suggestion that when I gave a signal, such as touching my nose, he would get up, walk over to the window, open it, and sit back down. Then I would give him another suggestion to forget the original suggestion as well as the signal. We would then demonstrate some other hypnotic phenomena, and I would eventually bring him out of hypnosis.

Unfortunately, hypnotic amnesia is difficult to achieve, so it didn't always work. When it did work, I would ask the person why he'd opened the window. Usually he would be surprised, defensive, and possibly even angry, saying, "What do you mean? You just asked me to open the window!" But occasionally the person would say something like, "Well, it was getting a little stuffy in here. I hope you don't mind my opening the window." This is what psychologists call confabulation, an unconscious "filling in" of missing information. I believe that in these cases with the hypnotic amnesia perhaps more complete, the frontal cortex was filling in the missing piece the way it does with the blind spot in the eye. It was being asked a question and, accessing all the information that it had available, came up with the most reasonable answer.

Ordinarily, our sense organs relay incoming information to the cortex, which analyzes it and comes up with conclusions about the state of reality. These conclusions can of course result in our experiencing emotions or urges to do things. This is a continuous process since new information is always coming in and being added to the analysis. Even when we reach to grasp something, our eyes monitor where our hand is so that the brain can direct our motor neurons to make the proper adjustments. So, normally, if we're not sure if the door is locked, we check it, and then use that new information to guide our next action.

The single most perplexing phenomenon in OCD is that people seem to be unable to alter their perceptions based on new information, whether intellectual ("I know that this doesn't make sense") or experiential ("I already checked the lock many times"). Researchers have even studied memory in people with OCD, because it looks as though they might have forgotten that they just checked. But it turns out that people with OCD have memories that are just as good as people without OCD, although they are often less sure of their memories.

It is probable that in OCD, the executive part of the brain, specifically the frontal cortex, receives false alarms of danger. As with deja vu or phantom limb pain, the individual experiences a very real sense or feeling that may be incompatible with the cognitive knowledge from other parts of the brain. These "emotional hallucinations," as I term them, are hard to ignore for two reasons. First, they are danger signals, not "all clear" or even neutral signals. Second, for most of our experiences, our brains work quite well. We have rightly come to trust our perceptions. The optical illusions that accompany this article are so compelling because they are accurate corrections virtually 100% of the time.

Having received incorrect data, the frontal cortex still attempts to do its job by making sense out of what it has been told. The false alarm, the vague perception of serious danger, could occur at any time, although scenes of transition (going through a doorway, driving down a street, initiating an activity) seem to be especially vulnerable times. Perhaps those are times we do a quick scan of our internal gauges or ask ourselves if we might be forgetting something. Imagine what it might feel like to be driving down a street and suddenly experience a powerful feeling that "something's dreadfully wrong." In this particular situation, your frontal cortex is more likely to consider the possi-

bilities that you've hit a pedestrian or that you forgot to lock your house than that you made a typo in that email you sent out yesterday. For one thing, the cortex is going to consider more proximate causes: Why am I experiencing this feeling right now? Also, for another thing, the cortex is going to look for something that would be expected to cause serious distress, because that's what you're feeling.

The feeling of danger can be specific or vague. It might not even be perceived as "danger" (which usually has an element of specificity); it may be perceived as a vague feeling that "something's not right." Whatever kind it is, though, it's typically accompanied by a strong feeling that one has to do something about it. Thus, the general feeling experienced in OCD is usually of the type, "There's something very wrong and I need to do something about it."

The idea of a person with OCD's frontal cortex (the "executive") receiving false messages is not new. In fact, Dr. Scott Rauch and other researchers attribute much of the problem to a brain structure called the striatum, which is sometimes referred to as the "executive secretary" because it helps screen incoming information and directs the executive's attention to what it considers important. In OCD, it is suggested that the striatum is doing a poor job of screening information for the executive, specifically by labelling unimportant information as important. (Trust executives to blame mistakes on the secretary!)

What I propose is that the original false message may be entirely emotional in nature, with virtually no content, hence an emotional hallucination. When the frontal cortex receives the message that "something is very wrong and you need to do something," it immediately starts looking at the most likely explanations. Check other senses: Nose, do you smell smoke? No. Hmmm, how about the door? Could it be unlocked? Check the door. It's locked. Good. But the alarm signal is still there! Better check it again.

Because the emotional hallucination is coming along the very same pathway that real danger signals use (as in phantom limb pain), the message received by the frontal cortex is totally real. But because it's a false alarm, not resulting from cortical analysis, new information has little if any effect in modifying it.

So when a person with OCD explains that she is unwilling to take her shopping cart down the aisle with the pesticides because maybe the poison molecules could work their way through the pesticide can, jump through the air, land on the food in her cart, and work their way through the food containers, I think the frontal cortex is doing what it's supposed to do: It's coming up with the best explanation it can that fits all the available facts. But again, one of the "facts" it has accepted is actually an emotional hallucination that there is great danger that needs to be dealt with.

This emotional hallucination is as totally real as the phantom limb patient's physical pain, coming into the frontal cortex with all of the credibility of a real danger message. And, we find it just as difficult to ignore these false messages as to ignore the cues of depth or shadows when viewing optical illusions. Even when we know the messages are false, and even when we want to ignore them, we simply can't.

So how does this explanation of OCD affect my treatment? First, it helps people separate themselves from their OCD. Expanding on Dr. Jeffrey Schwartz' famous expression (from his book *Brain Lock*), "It's not me; it's my OCD," I suggest that people think, "It's not real; it's an emotional hallucination. And I don't have to act on it." Second, it helps people reconcile how something can feel so incredibly real yet still be false. Third, it provides a neurological rationale for the treatment, namely, the perfectly natural and reliable phenomenon of habituation.

I give several examples of habituation, from the body's rapid adaptation to one-time stimuli such as jumping into a cold river or turning on a bright light at night to the long-term adjustment of living next to an airport or railroad tracks. The intensity of the stimuli has not changed over time, but your response has. And, in fact, neurologically speaking, any time you discard the old way of doing something and learn a new way, you are weakening certain neurological pathways and strengthening others. Every time you obey an OCD warning to check a lock one more time, you are inadvertently strengthening the pathway that sent you the warning message because you have labeled it as important. Instead, you need to ignore the message and weaken the pathway.

Specifically, I suggest that people with OCD take the following steps. Step One: You need to determine if this particular thought is an OCD concern or not. Because if it's not (you're anxious because you're drifting into oncoming traffic; you're anxious that if you don't drive your payment to the Post Office, you might get hit with a huge late fee), you should do the natural thing to reduce your anxiety. But if it is an OCD concern, then you should proceed to Step Two.

How can you determine if it's an OCD concern or not? Because OCD concerns are irrational and non-OCD concerns are rational, it is tempting to try to determine if the concern is rational or not. But there is a huge trap there, which is that OCD would love nothing better than to have you debate the issue with yourself all day long, or perhaps send you to the computer to research the issue more fully on the Internet. A better way is to look simply at content area. For one individual, if it has to do with germs, it's OCD; for another, if it has to do with arranging things symmetrically, it's OCD, and so on.

Step Two: Remember that it's an emotional hallucination and that you don't have to act on it. If this is reassuring, I don't mind – not all reassurance is bad! However, most people are not particularly reassured by this, nor do they fully believe it. That's ok too; but I do want them to go through that thought process each time they have an obsessive thought.

Assuming that OCD is still bombarding them with dire threats should they not perform their compulsion ("What if Dr. Mansbridge is wrong, and this time it's not an emotional hallucination but real?"). They should go on to Step Three, which is: "Don't argue with OCD, agree!" As many people know, agreeing can be the quickest way to end an argument. I stress that they don't actually have to agree, but they should pretend that they do. Even so, this can be most painful.

I give an example of a schoolyard bully (a great metaphor for OCD) teasing a poor child with a worm, threatening to make him touch it with his tongue. The bully knows, the whimpering boy knows and everybody watching knows that the bully is in complete control. If the child could (and this is a big if), the very best thing he could do would be to take the worm, say, "Ooh, looks tasty," pop it into his mouth, lick it clean, pull it out and hand it back, saying, "That was good. Got any more?" I'm not sure I would be willing to do that, but if the child could, that would let everyone, including the bully, know that the child had regained the upper hand. And this would be true even if everybody knew that the boy was "playing a role" and didn't really believe it was tasty. The important thing is to stand up to the bully and let him know you're not afraid of his threats.

So if OCD threatens you by saying that if you don't do some compulsion, grandma will get sick and die, say, "Oh well, she's getting old anyway." Or if you worry that you might have run over a child, say, "Ha! That'll teach them not to play so close to the road!" Outrageous? Horrible? Of course. Pretending to be outrageously

(continued on page 8)

Research Digest

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

OCD often begins in childhood. The following studies are on the course of OCD in children, the possible causative role of streptococcal infection in some children with OCD, and treatment with cognitive-behavior therapy, serotonin reuptake inhibitors and their combination.

Long-term outcome of pediatric obsessive-compulsive disorder: a meta-analysis and qualitative review of the literature

Acta Psychiatrica Scandinavica, 110:4-13, 2004, S.E. Stewart, D.A. Geller, M. Jenike et al.

Looking at the long-term outcome of child/adolescent-onset OCD, data are reviewed from 22 studies with follow-up periods ranging between 1 and 15.6 years. Combining study findings, the average persistence (continuation of OCD) rates were 41% for full OCD and 60% for full or subthreshold OCD. This indicates a 40% remission rate, meaning 4 out of 10 children or adolescents diagnosed with OCD no longer met the diagnosis for full or subthreshold OCD at follow-up. Earlier age of OCD onset, longer length of time suffering with OCD, and inpatient status were associated with a significantly increased rate of persistence. Additionally, poor response to initial treatment was associated with greater OCD severity at follow-up. It was not possible to separate overall remission rates from true remission rates (those who remain symptom free without ongoing treatment). Reviewers concluded that long-term persistence of childhood OCD may be lower than believed.

PANDAS: a model for autoimmune neuropsychiatric disorders

Primary Psychiatry, 11(4):28-33, 2004, S.E. Swedo and P.J. Grant

Streptococcal infections may trigger OCD in some children, a disorder referred to as PANDAS (pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections). This article gives two case studies of PANDAS, describes clinical features, reviews evidence for its autoimmune etiology, and outlines treatment strategies. The onset of symptoms is abrupt, even overnight in some cases. Symptoms may remain severe for several weeks or longer and then gradually subside, often disappearing completely. A new streptococcal infection precipitates the reappearance or worsening of symptoms. This remitting-recurring course differs from the gradual onset and persistent symptoms usually seen in childhood-onset OCD. New, still being researched immunomodulatory treatments (intravenous immunoglobulin therapy and plasma-exchange transfusions) may be helpful for a severely impaired child. However, for most children in the PANDAS subgroup, standard cognitive-behavioral therapy and/or serotonin reuptake inhibitor medication therapy and antibiotic treatment of streptococcal infections are recommended. There have been recent reports of PANDAS symptoms resolving after tonsillectomy. However, unreported clinical experience of these authors includes children whose PANDAS had begun only after tonsillectomy. Recognition that symptoms may have a poststreptococcal etiology should lead to evaluation and treatment of streptococcal infections. Antibiotics should be used to treat proven infections quickly and adequately. If a child has an abrupt recurrence of OCD, a rapid strep test should be obtained, backed up by a 48-hour throat culture if the rapid test is negative.

Cognitive-behavior therapy, sertraline, and their combination for children and adolescents with obsessive-compulsive disorder: the Pediatric OCD Treatment Study (POTS) randomized controlled trial

JAMA, 292:1969-1976, 2004, Pediatric OCD Treatment Study (POTS) Team

Research on treatment of OCD in children and adolescents supports the use of cognitive-behavior therapy (CBT) or drug therapy with selective serotonin reuptake inhibitors (SSRIs). However, little is known about their combined effectiveness. Funded by the National Institute of Mental Health, the Pediatric OCD Treatment Study (POTS) is a randomized controlled trial conducted in three academic centers: (Duke University, University of Pennsylvania and Brown University). Patients (112 children and adolescents) were randomly assigned to receive CBT alone, sertraline (Zoloft) alone, CBT-sertraline combination, or pill placebo for 12 weeks. Patients treated with CBT, either alone or in combination with medication, had the most improvement as determined by a Children's Y-BOCS score of 10 or less which the authors defined as "clinical remission." Sertraline alone was superior to placebo, however, more patients receiving CBT alone responded than did those receiving sertraline alone (39.3% versus 21.4%). Most effective was the combination of CBT and sertraline where 53.6% achieved "clinical remission." Sertraline was well tolerated and there were no episodes of mania, suicidal thoughts or suicide attempts during the course of the study. Researchers concluded that children and adolescents with OCD should begin treatment with CBT, either alone or in combination with medication.

Case study: Successful medication withdrawal using cognitive-behavioral therapy for a preadolescent with OCD

Journal of the American Academy of Child and Adolescent Psychiatry, 43:1441-1444, 2004, B.J. Sallinen, D.W. Nangle and A.C. O'Grady

Medication is an effective OCD treatment, but its discontinuation is usually accompanied by the return of OCD symptoms. This is an impressive report of the effectiveness of cognitive-behavior therapy (CBT) for an 11-year-old child with contamination obsessions and cleaning rituals. Medication, a combination of clomipramine (Anafranil) and fluoxetine (Prozac) greatly improved her functioning at school and stabilized her OCD symptoms, but she continued to experience distress from obsessions about germs. CBT was added and reduced her daily number of obsessions and avoidance behaviors after three sessions. When medication was tapered, the OCD symptoms continued to decline. After CBT treatment and without medication, she no longer met diagnostic criteria for OCD. At the 4-month follow-up, treatment gains were maintained and she remained medication free.

Paroxetine treatment in children and adolescents with obsessive-compulsive disorder: A randomized, multicenter, double-blind, placebo-controlled trial

Journal of the American Academy of Child and Adolescent Psychiatry,

Research Digest

43:1387-1396, 2004, D.A. Geller, K.D. Wagner, G. Emslie et al.

The effectiveness and safety of paroxetine (Paxil) for the treatment of pediatric OCD was evaluated. Of the 203 children and adolescents in the study, 98 received paroxetine (10-50 mg/day) and 105 received placebo. The response to paroxetine was significantly greater than response to placebo and compared favorably with response reported in other pediatric OCD trials with other serotonin reuptake inhibitors including sertaline (Zoloft), fluvoxamine (Luvox) and fluoxetine (Prozac). Adverse effects were mild to moderate with 10% of patients discontinuing paroxetine because of adverse effects. The results of this study indicate that paroxetine is an effective treatment for children and adolescents with OCD. The U.S. Food and Drug Administration (FDA) approved paroxetine for the treatment of adult OCD in 1996 but it is not approved for pediatric OCD. Currently there are concerns that paroxetine taken by children and adolescents may increase the risk of suicidal thoughts or acts. In this study, one adolescent reported suicidal thoughts, but there was evidence that this was not caused by paroxetine.

Behavioral treatment of a child with PANDAS

Journal of the American Academy of Child and Adolescent Psychiatry, 43:510-511, 2004, E.A. Storch, A.C. Gerdes, J.W. Adkins et al.

Research on several PANDAS treatments has been reported. In particular intravenous immunoglobulin therapy and plasma exchange have produced moderate reductions in symptom severity (40% and 55%, respectively). Both procedures have side effects and at this time are experimental. Behavior therapy is highly effective in treating pediatric OCD and is assumed useful for PANDAS. One week after having a sore throat and testing positive for a streptococcal infection, this 6-year-old boy developed obsessions about choking and contamination. His fears of choking increased to the point he refused to eat solid foods. A behavioral program was set up that progressively exposed the child to solid foods accompanied by reinforcement by his parents for positive eating. This is the first published report supporting the effectiveness of behavior therapy in treating OCD associated with PANDAS.

"Mr. Worry: A Story About OCD" *

By Holly Niner

Reviewed by Aureen Pinto Wagner, Ph.D.
The OCD and Anxiety Consultancy
Rochester, New York

"Mr. Worry: A Story About OCD" is a charming new book for young children with OCD and a welcome addition to the sparse resources on OCD for children and their families. It is both very well written and beautifully illustrated, making it very appealing for children. As the parent of a child with OCD, the author Holly Niner has dealt with OCD firsthand and eloquently tells the story of her son's experience with OCD.

Young Kevin, the hero of the book, is having increasing difficulty getting through each day. He repeats things often and has an elaborate bedtime ritual that involves straightening items, checking under his bed and in his closet, and asking for reassurance that he is well and safe. Kevin's OCD also goes to school with him and makes him unsure if he is doing everyday routines correctly. He checks frequently with his teacher. Most upsetting for Kevin is his sudden doubt that his mother might be an alien. It is particularly poignant when children are assailed by fears and doubts about the ones they trust, need and love the most – their parents. To doubt the identity and safety of a parent is very frightening for a child.

But, as is true of most children with OCD, Kevin knows that something is very wrong. He wonders if he is crazy. His parents know it is time to seek professional help. Kevin meets a counselor who assures him he is not crazy and gives him a name for his fears. She tells Kevin that OCD is something that happens in the brain – it's as if OCD is making phone calls with worry messages and pushing the redial button repeatedly. She tells Kevin that he can learn to "hang up" on the worry messages, just like he would hang up on a wrong number call. Kevin is afraid that he cannot do that, so he is offered medicine to help him. The therapist explains to him that the medication will help him "hang up" on OCD in the same way that good running shoes would help him be a better runner.

With the combination of medication and the counselor's guidance, Kevin learns how to stop listening to Mr. Worry gradually. He stops doing his rituals one step at a time and begins to feel much better. However, Kevin also finds out that Mr. Worry calls more often when he is tired or stressed. He learns that dealing with Mr. Worry is a marathon, not just a race. Most of all, he learns that he is in charge, not Mr. Worry.

This delightful story conveys compassion and empathy for the child with OCD, and gives hope and direction for recovery. The message that children with OCD are neither crazy nor alone is very important, because OCD can be bizarre enough to make children doubt their sanity. Children and their families need to know that effective treatments are available. It is particularly important that children know they can take charge of OCD by changing their responses to it.

Mr. Worry is reflective of the author's experience of OCD and treatment with her own child. She describes the child's journey through diagnosis and treatment in a clear and logical fashion. As a professional who treats OCD, I believe that two issues bear clarification for the larger population of children with OCD. First, we do not know what causes OCD. Therefore, the author's note in the preface that OCD is "due to a chemical imbalance" in the brain does not acknowledge that OCD is far more complicated than a "chemical imbalance," which is only one of many risk factors for OCD.

Second, the hero in the story benefited from both medicine and learning how to take charge and dismiss Mr. Worry (which suggests cognitive-behavioral therapy [CBT]). It is true that some children need the combination of medicine and CBT to gain mastery of OCD. However, there are many children who can overcome OCD with CBT alone, without medicine. Because Mr. Worry is the treatment experience of one child, it does not convey this very important point. Many parents are understandably very hesitant to use medication with their young children, so they need to know that CBT alone is very effective for many children and there is hope for their child's recovery without medication. Neither of these issues detracts from the value of this wonderful book and I recommend it highly.

Dr. Wagner is the author of "Up and Down the Worry Hill," "What to do When your Child has Obsessive-Compulsive Disorder: Strategies and Solutions" and "Treatment of OCD in Children and Adolescents: A Cognitive-Behavioral Therapy Manual."

** Mr. Worry can be purchased from the OCF Bookstore.*

How I Treat OCD

Understanding the Neurology of OCD

(continued from page 5)

indifferent in situations that actually frighten you is much more effective than simply acknowledging that the possibility of the bad outcome exists. It's the difference between touching the worm with your tongue and licking it clean and pretending to enjoy it.

You need to get in OCD's face and show it you can't be scared into doing those compulsions. Good things to say when the bully threatens you with some horrible outcome are, "Oh well, so what?" and "Let's say you're right. What's your point?" If you try to argue that the dreaded outcome won't occur, OCD can always come back with, "But what if you're wrong?" and you're back where you started.

Because we use language when we think, it's important that we use words accurately. Although we literally can't ignore emotional hallucinations, I do point out to patients that when they say they can't resist a compulsive urge, what they really mean is that they're unwilling to. It's not that they can't touch the faucet in a public rest room; they're unwilling to. And when they say they have to wash their hands, what they mean is they feel they have to. That's fine. I'm unwilling to eat a cockroach, but I could if someone put a gun to my head.

I see the treatment of OCD as similar to getting in shape physically. For one thing, given a choice, most people would prefer lifting a lighter weight than a heavier one, just as most people would prefer an anxiety-reducing activity over an anxiety-producing one. But if you're trying to get in shape physically, your attitude is reversed. You look forward to being able to lift heavier and heavier weights, and you view the effort you're expending as worthwhile. In the same way, it's important to view your choice to resist compulsive urges as making you stronger – toughening up your "mental muscles." You want to reconceptualize tolerating the anxiety of ERP as a challenge, not something to be dreaded and avoided.

And just as it makes good sense to start a physical exercise regime with very low weights, especially when you're out of shape, it's good to start ERP with exercises that are not too anxiety-provoking. This will help ensure that you have successes from the beginning. You can always increase the "weight" later. My first ERP assignment is often the equivalent of physical stretching exercises: Test OCD a little by gently resisting some compulsive urges. Find out where it's weaker than you may have expected and where it's stronger. Test your limits, but gently. Try resisting the urges a little bit, but be careful not to overdo it.

If you proceed too slowly, all you've lost is a little time. But if you go too quickly, you may find the process too unpleasant and be tempted to give it up. At the beginning, any progress is a huge change from baseline. Mathematically, going from zero to any positive number, no matter how small, is a step in the right direction.

Just as a physical trainer cannot know what weights you should start at, an ERP therapist should not pick specific goals. I will remind people that the more they can do, the faster they'll get better; but I'll let them set their own goals. That's their area of expertise, and it helps their commitment to the therapy. However, if the person consistently sets overly easy goals, then I will do some therapeutic arm-twisting.

Exposing yourself to obsessive thoughts and resisting compulsive urges is bound to be anxiety-provoking. But what is therapeutic is the exposure, not the anxiety. I disagree with those who insist that you not do anything to relieve your anxiety. Some therapists will even try to increase patients' anxiety by having them drink several cups of coffee before doing exposures. What will get you over your fear of heights is going on the Ferris wheel, not the terror you experience by doing it, even if you need to take a tranquilizer or even close your eyes at first to do it. The important thing is to go on the Ferris wheel. Eventually, of course, you should get to the point where you can open your eyes; and when your fear has dropped further, you can and should forego the tranquilizer.

The best argument for lowering your anxiety is that it will make the task less unpleasant and thus increase your motivation for doing it. Be careful, however, not to substitute other rituals. The best argument for not trying to lower your anxiety is that you will benefit from reconceptualizing anxiety from something to be dreaded and avoided at all costs to something that is in fact tolerable and will help make you stronger. One of my patients has relabeled it as "therapeutic energy." Others continue to think of it as anxiety but begin to think of it as "only anxiety." Again, the words we choose can make a huge difference.

I believe that presenting OCD as an neurological disorder helps patients understand their disorder, reduces stigma, promotes rapport, and provides an excellent framework and rationale for doing ERP therapy. We are far from fully understanding the neurological nature of OCD, and I am far from understanding completely what we do know. I am aware that I have vastly oversimplified some complex neurological concepts, and many of my conjectures may turn out to be incorrect. However, the model I have presented appears to be fairly robust, and I believe is consistent with what we currently know. More importantly, I have found it to be helpful in clinical practice.

How I Treat OCD in Children and Adolescents: The Importance of Readiness

By Aureen Pinto Wagner, Ph.D.
Clinical Associate Professor of Neurology, University of Rochester School of Medicine and Dentistry, and Director, The OCD and Anxiety Consultancy, Rochester, NY

Cognitive-behavioral therapy (CBT), specifically exposure and response prevention (ERP), which involves confronting obsessive thoughts while refraining from rituals, is accepted as the mainstay of treatment for OCD in adults. A decade after the efficacy of CBT for childhood OCD has been established by the pioneering work of John March, M.D., John Piacentini, Ph.D., and others, the great majority of children still do not receive CBT. Discussing the many possible reasons for this regrettable situation is beyond the scope of this article. I believe that there are many clinicians who would like to provide CBT for children; however, those without specialized training in CBT do not have the know-how or the time to effectively adapt rigorous research-driven protocols to everyday clinical practice. Making the leap from science to practice

involves recognizing the many fundamental differences between specialty research clinics and general community practice.

My focus in treating OCD in children and adolescents has been on making empirically-proven CBT user-friendly for the clinician, the child and the family in the everyday clinical world. Although the core ERP strategies are robust, the realities and constraints of community practice call for creativity, flexibility and clinical artistry in implementation. I believe that ERP works. Getting children (and sometimes parents) to understand it, believe it, and do it – therein lies the challenge. Through my early years of less than desirable success in treating youngsters with OCD, I asked myself, "How can I get a child to buy into the treatment? How can I bridge the gap between hearing, believing and doing? What can I do to engage children and families to stay in treatment without dropping out prematurely? What works and what doesn't?" These questions and their answers direct how I treat OCD today.

My experiences led me to develop the *Worry Hill* metaphor (Wagner, 2000; 2002) and subsequently the *Worry Hill Treatment Protocol* (Wagner, 2003a; 2003b) geared towards the clinical practice setting. Many clinical tools, including easy-to-use therapist and patient forms on CD-ROM, Teaching Tools, the Feeling Thermometer and detailed examples of ERP for a variety of OCD symptoms make the protocol easily accessible to clinicians. The Worry Hill Protocol emphasizes specific aspects of treatment delivery in the context of the four phases of treatment, as described below (see Wagner, 2003b for a detailed description).

The Worry Hill Treatment Protocol

1. Building treatment readiness prior to starting ERP.

2. Proactively defining the collaborative but unique roles of child, parent and therapist in treatment.

3. Helping the child comprehend, accept and experience the key concepts of anticipatory anxiety, exposure and habituation via the metaphor of the Worry Hill.

4. Setting realistic expectations about the course of treatment and outcome.

5. Fostering self-reliance in recovery.

The Four Phases

Phase 1: Biopsychosocial assessment and treatment plan (1-3 sessions; each session is a 50-minute clinical hour)

Phase 1 lays the essential foundation for successful treatment, and focuses on a sensitive and comprehensive understanding of the child's OCD symptoms in the larger context of the child's family, school and social environments. Initial diagnosis is followed by a thorough OCD symptom analysis and a customized treatment plan.

Phase 2: Building treatment readiness (1-3 sessions)

In the fifteen years I have been treating OCD, I have learned that readiness is an essential precursor to treatment that is too frequently overlooked. *The Worry Hill Treatment Protocol* is unique in its emphasis on cultivating treatment readiness, devoting an entire phase in treatment to this critical process.

In the typical clinical setting, families seeking help for a child's OCD frequently present in a crisis. There is a sense of urgency and high expectancy for quick success when children are unable to function and parents are at their wits' end. The therapist is often confronted with the child and family's suffering and wants to help as quickly as possible. I find myself in that situation time and again and I want to alleviate their pain. But I have learned that jumping into ERP hastily almost always backfires, because neither the child nor the family is ready for what ERP entails.

Clinicians with insufficient training or experience may unwittingly launch into ERP prematurely, before the child is equipped with the proper understanding or tools to cope with the initial rise in anxiety with ERP. The child may become afraid and unwilling to go through with ERP. When such "false starts" occur, children, parents and even therapists are inclined to abandon treatment and conclude that it is a "failure." False starts in treatment are often attributed to the "unmotivated" child, a pejorative connotation, suggesting laziness or nonchalance. Children do not generally enjoy having OCD, and are therefore motivated to be rid of the burden OCD places on their lives. However, they also need to be ready to participate in treatment. To be ready, they have to be able to channel the desire to get well into the action needed to get well.

Why is readiness so crucial to treatment? It's because CBT involves actively learning and using a new set of skills to overcome OCD. It is very similar to learning any other new skill such as riding a bicycle – no one can ride a bicycle for a child. Adults can help the child get started, but eventually, the child must learn to ride for himself and he will do it when he's ready. Likewise, the child needs to face his fears for himself to learn that they are unwarranted. No one else can do it for him. He will only do it when he's ready; ironically, when he feels pressured, he is less likely to be ready. Carefully and thoughtfully preparing the child and family for treatment is an important investment with huge dividends. The chances of success in CBT are likely to be increased when the child and family are ready for treatment.

I believe that clinicians in community practice need specific guidance on cultivating readiness in the child and family before they proceed with ERP. Does the readiness phase delay the recovery that the child and family sorely need? On the contrary, treatment may proceed a lot faster and easier than anticipated by the child and parents. In my practice, children with moderate to severe symptoms often master OCD within four to eight sessions of ERP after they have been through one to three sessions of building readiness, making the total duration shorter than average. Further, it is a therapeutic process from which children and families benefit greatly, as you will read below. In essence, treatment has already actively begun; it is only the ERP phase that is postponed. Building treatment readiness also strengthens the therapeutic alliance necessary for the child and family to take on the potential risks of ERP.

Building readiness is a planned and systematic process that involves active clinical direction and four steps: 1) stabilization, 2) communication, 3) persuasion and 4) collaboration.

1) Stabilization of the child and family crisis. A child who is overwhelmed and struggling to function each day simply may not have the wherewithal to consider CBT. Just getting through each day with OCD may consume all his energy. Overzealous implementation of ERP at this time merely adds to the child's sense of burden. Stabilization involves providing the child with respite from the dual challenges of OCD and everyday living through flexible expectations and temporary accommodations at home and at school. I encourage families to function in "survival mode," to set priorities and cut back on discretionary commitments in order to conserve time and energy for treatment. In some instances, the child may need medication to reduce the severity of symptoms prior to engaging in ERP.

Families need stabilization too because calm, supportive and allied families are better equipped for the demands of ERP. Parents who are highly distressed need support, stress-management, and conflict resolution techniques to regain equilibrium before they can support their child during ERP. A "no blame, no shame" approach helps reduce hostility, guilt and polarization in the family. Parents who realize that they have been inadvertently "enabling" their child's OCD often feel guilty and ask me if they should stop. They are surprised when I say, "No, please continue enabling, because your

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How I Treat OCD

The Importance of Readiness

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child is not ready to manage OCD without your assistance right now. We will discuss and plan the best time and way for you to stop later."

2) Effective communication. Perhaps the most critical part of treatment readiness is helping children and families understand how rituals and avoidance strengthen OCD, and how the key CBT concepts of exposure, habituation and anticipatory anxiety will help in treating OCD. OCD is overcome by confronting fears (exposure) and learning that they are false alarms, experiencing habituation (getting used to the anxiety, much like you get used to the cold water in the swimming pool) and understanding that confronting fears seems harder before you do it than when you actually do it (anticipatory anxiety).

The Worry Hill Treatment Protocol places significant emphasis on the child's comprehension, acceptance and temporal experience of anticipatory anxiety, exposure and habituation as the tools that make ERP easier for the child. In my clinical experience, children who comprehend the relationship between avoidance, exposure, and habituation engage more effectively in ERP. Exposure may be both counterintuitive and daunting at first glance; a child who is afraid does not exactly want to hear that he must face his fear and endure more anxiety. When children don't understand why and how ERP works, they are unnecessarily intimidated by it. When they do understand, they are willing to tolerate the initial anxiety experienced during ERP because they know it will increase and then subside.

"No magic, no mystery, no secrets, no surprises." I demystify treatment and remove uncertainty and apprehension at the outset by telling children and families that I am straightforward and open throughout the treatment. I convey the key treatment concepts in child-friendly language via the metaphor of riding a bicycle "Up and Down the Worry Hill." The *Worry Hill* represents a universal metaphor because almost any child, adolescent or adult can relate to the idea of riding a bicycle up a hill: "Learning how to stop OCD is like riding your bicycle up and down a hill. At first, facing your fears and stopping your rituals feels like riding up a big *Worry Hill*, because it's tough. You have to work very hard to huff and puff up a hill, but if you keep going, you can get to the top of the hill. Once you get to the top, it's easy and fun to coast down the hill. You can only coast down the hill if you first get to the top. Likewise, you can only get past your fears if you face them. You have to stick it out until the bad feeling passes. Then you will see that your fears do not come true. But if you give in to the rituals, it's like sliding back down the hill before you reach the top. You don't give yourself a chance to find out that your fears will not come true even when you don't do rituals." I use Teaching Tools to visually depict these concepts.

3) Persuasion. Effective persuasion involves helping children see the necessity for change, the possibility for change, and the power to change. Children are more readily persuaded when they have an accurate understanding of OCD and CBT. The child must be helped to see the benefits of overcoming OCD; this convinces him of the necessity for change. When he learns that OCD can be successfully overcome, and that many others have done it, he sees the possibility for change. I tell children stories of other children with OCD and how they rode up the *Worry Hill*. Children love these stories, which helps them realize that they are not alone and that others have gone before them. Hearing success stories gets families through despair by providing hope. Children also need to have perspective on how difficult ERP may be. I say, "Exposure may be hard, but probably not any harder than your life with OCD is right now. In fact, it is often harder to think about exposure than it is to actually do it. Besides, the hard work of exposure at least gives you a chance to get rid of OCD; the work you put into OCD right now only makes it worse."

Finally, the child must know that he has the power to change. He must understand that he can take charge and take control of OCD instead of letting it control him. The recognition that he has the power to change can be a liberating experience for the child.

4) Collaboration. Collaboration makes the child a vital partner in treatment. The child, parent and therapist have different but complementary roles to play in the child's treatment. The therapist's role is to guide the child's treatment, the child's role is to RIDE and the parent's role is to RALLY for the child (Recognize OCD episodes; Ally with your child; Lead your child to the RIDE; Let go so your child can RIDE on his own; Yes, you did it! Reward and praise). Parents are empowered to play a critical role in the child's treatment.

Proactively defining each of these roles before treatment begins can expedite progress by preempting the conflict and frustration that can ensue from misunderstanding. It also corrects the misattribution of power to the therapist. The child and family need to know that the therapist is not the one who will "fix" the child's OCD – it is the child who holds the power. I assure the child, "I will not force you to face your fears. You and I will discuss together what you will do when you're ready." Most children relax immediately and are more willing to listen and participate when they don't have to be on guard.

I deliberately do not begin ERP until the child voluntarily expresses readiness and willingness to proceed, and child and parents have agreed to their roles in treatment. I test the child's readiness by giving him the freedom to decide if he wants to go ahead – with no pressure from his parents or me. I tell the child that I do not want an answer immediately because I don't want to put him in an awkward position of not being able to back out gracefully. I give the child my telephone number to call with an answer within the next week.

I've rarely had a child refuse to participate in treatment when he understands what it entails and is given the freedom of choice. The child is more likely to be invested in his recovery and to take ownership of it when he perceives that he has control. When the child says, "Yes," it is often accompanied by the enthusiasm and zest of a conqueror, which is a marked change from initial caution, guardedness or fear.

When a child declines to participate despite proper preparation, it may be a good indicator that the child is truly not ready for CBT and therefore unlikely to benefit from it. The reasons for treatment reluctance must be examined, and other options such as medication may need to be considered. For some children, CBT may have to be deferred temporarily and attempted later when they are older, more mature or more willing.

Phase 3: The RIDE (4-10 sessions)

The focus in this phase is on ERP. All the preparation that has occurred will now come to fruition when the child puts ERP into action. The child has learned about ERP didactically. This is the experiential phase of the treatment. Now, the child

experiences in reality the temporal relationship between anticipatory anxiety, exposure and habituation. This experience provides evidence for the child that fears do not materialize and that anxiety dissipates without doing rituals.

The child is presented with the four-step RIDE acronym: (Rename the thought; Insist that you are in charge, Defy OCD – do the opposite; Enjoy your victory – reward yourself). These are the steps that enable him to successfully tackle the *Worry Hill*. The acronym helps break down ERP into concrete finite steps that structure and clarify the ERP process. The child knows exactly what to do and what to expect during ERP. The RIDE includes both cognitive and behavioral elements such as externalizing, taking control of OCD thoughts, ERP, and self-reinforcement. The Defy step is, of course, the most critical because this is the core strategy.

In addition to the auditory mnemonic aid of the RIDE acronym, children receive visual tools such as the *Feeling Thermometer* and the *Worry Hill Memory Card* to utilize during ERP. The logical steps, visual features of the Worry Hill and the RIDE acronym make the process of ERP easy to grasp, retain and recall, even in the midst of anxiety, allowing the child to take one step at a time.

The child is trained to become acutely aware of and experience, on cognitive, behavioral and physiological dimensions, the process whereby anxiety escalates during exposure and dissipates during habituation. Throughout the treatment, I utilize the Feeling Thermometer and Socratic questioning continuously to help children actively and tangibly experience the initial rise and peak in anxiety, the onset and continuation of habituation. "What's your feeling temperature now? Good, it's going up. That means you're riding up the *Worry Hill*, just as we expected! How does it feel now? See how your anxiety goes up before it goes down? What happened? How did it feel? Did your fears come true? How hard was it to do it?" When the child is ready for the next ERP exercise on the hierarchy, I review the child's previous ERP experience to prime him for the upcoming one. This experiential learning provides the child with powerful tangible feedback about the process whereby fears can either be cemented or extinguished. The "aha" experience that typically ensues allows the child to see the perfectly logical sense behind ERP. The *Worry Hill* soon becomes an integral part of the child's response to OCD.

Children who are well prepared for the *Worry Hill* often find that it is somewhat of an anticlimax – it is simply not as "scary" to face their fears as they imagined. They also begin to generalize surprisingly fast, resulting in a rapid progression through the ERP hierarchy. The "slow" start now becomes a fast ride! They are often eager to rise to the challenge of ERP. I remember one child who had major meltdowns every morning because she couldn't wear shoes to school – they didn't feel "right." When I suggested she try them on only until I counted to 10, she agreed and stepped into them gingerly. She then smiled and asked me to keep counting; she'd decided she would wear them for 10 minutes. Before the time was up, she announced triumphantly that she would wear the shoes to school that day. She walked out of my office with pride, while her mother shook her head in amazement, recalling all the mornings of screaming and tears – all of that dissolved in just a few minutes.

Working closely with parents and families is a must. During this phase, we proactively discuss realistic expectations about the duration and course of treatment, as well as the time frame and nature of improvement. This discussion removes misconceptions and ensuing disillusionment with treatment. Given the urgency for relief, there is often palpable disappointment when parents hear that it may be 3-6 weeks before their child is appreciably better. However, when they understand what treatment entails, most families see that it makes sense and are accepting of the fact that recovery is a journey, not an event. Parents need to know that the child's progress cannot be measured on a linear curve – that each child is unique, and that progress can occur in "fits and starts" and can have ups and downs. Most importantly, parents need to be prepared for the "extinction burst" – the child's resistance to change because the status quo is more familiar and comfortable. Realistic expectations are reinforced throughout treatment.

Phase 4: After the RIDE

Parents and children need to be prepared for the reality that OCD "slips" or relapses can happen either unexpectedly or at times of stress and transition. When prepared, they are more likely to have an organized and productive response, and less likely to become demoralized. Relapse recovery training involves having realistic expectations about the future, recognizing the early signs of relapses, keeping things in perspective and intervening immediately. The metaphor of falling off a bicycle is extended to describe slip recovery: "When you fall off your bicycle, you pick yourself up. If you made no attempt to get up, you wouldn't get anywhere. If you want to move on, you get up, dust yourself off, survey the damage, attend to it, and get right back on that bicycle."

During this phase, there is a shift in focus to building self-reliance in the child. Taking charge and taking control is an important element of the RIDE. The child initially gets substantial guidance and support during ERP from therapist and parents. However, once the child has experienced success and knows the process, the therapist and parent must gradually phase out their assistance in order to foster the child's self-reliance in managing OCD. The more self-reliance the child develops, the better equipped he is for future recurrences of OCD – he does not have to wait for help and can intervene quickly. Fostering self-reliance is critical in order to fully internalize the strategies and tools learned. I encourage the child to begin to design his own exposures during this phase of treatment. I encourage parents to redirect the child who seeks help in coping to first ask, "What do YOU think you need to do with that OCD thought?" rather than providing suggestions reflexively.

To conclude, we know that CBT works; we need to continue to make it more accessible in community practice. Families all over the country struggle to find CBT therapists who can help their child overcome this debilitating illness. The desperate search for therapists is a frequent theme on the online parents' support group, ocdandparenting (at Yahoo groups, http://health.groups.yahoo.com/group/ocdandparenting). When I present workshops, I am approached by many therapists and school professionals who are eager to learn how to use CBT with children. They tell me that they need more in-depth training and supervision which is very hard to find. Most CBT workshops provide a cursory overview, but not enough of them give parents the know-how and confidence to undertake it. We need to focus more on disseminating CBT to clinical practitioners so that the many children and families who are suffering needlessly can have a chance at taking back their lives from OCD.

Dr. Wagner is a clinical practitioner and the author of an integrated set of resources for children and adolescents with OCD, their parents, and their therapists. Her books are available through the OCF Bookstore. Dr. Wagner also provides in-depth CBT training for professionals and workshops for parents.

OCD Treatment: Fighting Back

(continued from page 1)

slightest chance they really will protect my loved ones or me? Yet you've had enough of being blackmailed by your OCD. You want your life back.

After great thought, you decide to take on your OCD and go through the painful, exhilarating process of gaining mastery over your symptoms. You understand that you may never be entirely free of your obsessive thoughts, that you may find in periods of stress that your OCD regains some strength. But you know you can minimize its place in your life overall.

You've found a therapist who specializes in the treatment of choice for OCD: cognitive-behavioral therapy (CBT). She tells you she's going to work with you using a specific kind of CBT with yet another set of initials, called exposure and ritual prevention (ERP).

"Your mind and body have been held hostage by your OCD symptoms but you can choose to fight back," she explains. "You can break the connection between your anxiety-producing obsessions and the irrational rituals meant to eliminate them. Then you can see, firsthand, that nothing bad happens."

"But I've tried to fight back a million times," you reply. "I always end up back in the throes of my OCD."

"I'm sure you've tried hard to fight your OCD," your therapist agrees. "We're going to use that motivation of yours and help it along with a structured systematic program that will allow you to confront your fears without ritualizing."

"In the past, your battle against OCD has been like that of a would-be swimmer who jumps in a pool, finds the water freezing, and jumps out. He tries again every week, but always climbs out quickly, feeling too cold," she says. "But now imagine that he decides he's going to stay in the water until he can stand the cold. With some new mental weapons to handle it, he manages to stay in the pool for an hour at a time. As the minutes pass, he begins to adjust to the temperature. He repeats the exercise several times that day and then every day for the next month. Over time it gets easier; eventually he dismisses his initial "cold" thoughts because he knows he'll stop noticing them shortly. He no longer avoids the water; and, when he's in it, he learns he can handle the cold. That could be you with your OCD."

MAPPING OCD'S ROLE IN YOUR LIFE

To start, you and your therapist do a comprehensive assessment, covering your history and other relevant concerns. You both agree you're ready to start tackling your OCD so you examine your symptoms today. You say you worry about harming others, and it shows up in a variety of checking symptoms.

"I'm afraid I'll run people over with my car, and at home I'm afraid I'll burn my house down by leaving an appliance or the lights on, or get us robbed by forgetting to lock the doors or windows," you tell your therapist. "Every time I drive past a pedestrian, I look back for a body. When I get home, I ask my wife repeatedly to tell me that I couldn't have hit anyone without knowing it. I keep checking the locks, the stove burners, the lights, the electric blanket in the winter and the fans in the summer. It's exhausting – and it makes me feel crazy."

Your therapist gives you your first assignment. She tells you, "over the next week, play detective. Look at your life as though a video camera were following you around. Record on a sheet all of your obsessive worries and notice exactly what you do in an attempt to make them go away."

"It's even worse than I'd thought," you tell her when you return the next week. "I realized that when I'm driving past someone, I listen for the thump of a body going under the wheel or a scream of pain. When I get out of the car, I even pass my hand over the body of the car to feel for new dents or skin or hair from someone I hit. Then I switch on the news at home to check for any reports of hit-and-run accidents where I drove."

"Those were behaviors aimed at neutralizing the anxiety caused by the obsessive fear of hitting someone," she explains. "Did you notice any situations or thoughts you avoided so you wouldn't even trigger your OCD?," she asks.

"You bet. I realized that I drive blocks out of my way in the morning so I won't pass elementary school kids walking to school," you say. In the process of stepping back and watching your OCD manipulate you, you discover obsessive thoughts, rituals and avoidance behaviors that have become so habitual that you've stopped noticing them. "My OCD controls me even more than I realized," you say flatly.

USING YOUR MIND AS A WEAPON AGAINST THE OCD

"You've really been bullied by your OCD, haven't you?," says your therapist. "Of course, everybody has bad thoughts – What if I drop my infant down the stairs?; Did I turn the oven off when I left home?" What makes it hard for you is how long you spend worrying and trying to drive the demons away, and how much that affects your life. Most people let those bad thoughts go; they delete them like spam from their computer or junk mail in their mail box. For you, the thoughts are sticky; they won't let go. The OCD convinces you that your rituals will make the bad feelings go away, they'll make things right, or keep you or someone you love safe, so you keep doing them."

"That's right," you reply. "It's like a triple whammy. I'm upset by these disturbing thoughts and I'm mad at myself for taking them seriously, but I'm afraid to skip the ritual just in case it really works. Then I'm frustrated with myself for doing things that make so little sense!"

"The problem is that OCD is like a hungry, barking dog," she comments. "When you do your ritual to make the bad feelings go away, it's like you feed the dog a steak to get it to leave you alone. Instead it just gets bigger and louder and looks tougher and more insatiable. You feel like you better feed it bigger and juicer steaks, more and more often, to keep it from harming you," she says.

"I've noticed that," you exclaim. "I used to check my rear view mirror once, and now I need to check it three times to get any relief and even that doesn't last. A year ago, when I got home, my wife just had to reassure me once that I couldn't have hit anyone. Now I go back to her a half-dozen times throughout the evening for that reassurance. I keep needing more to keep the fears at bay. I feel like a drug addict."

"Well," she replies, "you've come in for treatment because you've decided to stop feeding the dog steak. You don't want to have to do rituals to make your obsessive thoughts go away and are tired of trying to avoid situations that might trigger those thoughts. You're going to be doing something very different by standing up to that snarling dog. You'll discover that it's bluffing; it's really a pussy cat who can't hurt you. You're going to label the OCD for what it is: an irrational belief that your rituals offer protection against those awful thoughts."

You ponder that. "I can see an OCD obsession as a hungry dog that I just make more greedy by feeding with my rituals. And you know what? I can also see it as an annoying mosquito bite. If I accept the itch and refuse to give in and scratch it, the itch eventually goes away. If I scratch it, it gets better at first. But then it gets worse and I just need to keep scratching more and more."

"Exactly," she replies. "I like that."

PLANNING YOUR TREATMENT STRATEGY

You discuss with your therapist whether to combine medication with the cognitive-behavioral therapy. She explains that a psychiatrist could consult with you about medication. There are antidepressants called SSRIs that have been found to help about half of all people with OCD. "They help the most when they're combined with CBT. But most people find their OCD symptoms return when they stop taking the medications so an SSRI alone isn't enough, even if it works for you. Therapy is the best tool for long-term change. Many people benefit from combining CBT and medication. It's up to you whether you want to use both," she says.

"Let me think about it," you reply. "I'll probably schedule an evaluation with a psychiatrist and then consider the options."

You and your therapist then begin preparations for the exposure and response prevention program. Already you have your notes from your own detective work. Together you create a detailed inventory of all your obsessive thoughts, rituals and avoidance behaviors. Then you rank your compulsions by the degree of distress it causes you to experience the obsession and imagine not doing the desired ritual.

From easiest to hardest, you list "hit-and-run" driving compulsions, followed by checking lights and various appliances, and finally checking doors and windows. You have many subtle distinctions for each category.

"In the car, I have the least anxiety when I'm driving on a deserted country road," you report. "My anxiety gets progressively worse driving on the highway and in a neighborhood, driving near a school, driving at rush hour and finally driving through a crowd, like before and after University of Michigan football games. I also realized I get more anxious when I'm tired, rushed, or stressed because of something like a fight with my wife or a stupid assignment from my boss," you note.

You and your therapist design your first ERP assignment. "You want to target a situation you really want to change," she says. That will motivate you to do the hard work ERP demands of you. But you don't want to pick something so overwhelming that you aren't willing to do it."

"I want to start with driving," you reply. Together you make a plan that will be hard – but not too hard. "Let's see if I have this down," you say. "The first week I'll drive an hour a day on the highway in the right lane, looking for opportunities to drive near cars or people on the side of the road. I won't use my "safety crutches" like looking in my rear-view mirror for bodies after passing someone, checking for dents when I leave the car, or asking my wife to tell me I didn't hit anyone."

Also, you increase your anxiety by adding exposure to your bad thoughts. You place sticky-notes all over the dash board. They read: "I hit someone." "There's blood on my grill." "I killed someone." You agree that you won't stop doing the assignment each day until you feel less anxious than when you started. You promise to record your anxiety and success for each ERP session on a form.

You've scheduled a double session with your therapist today so that when you finish your planning, you can go out in the car together. "In this therapist-assisted ERP, I can help you practice the work you'll be doing on your own," she says as you walk together to your car. "We'll do something just a little harder than your assignment while I'm here to give you support. That will make your daily homework less daunting."

For the next hour, she sits beside you while you drive on the highway, changing lanes repeatedly to increase your anxiety about hitting someone and then not looking in your mirrors to check. Your anxiety spikes at first but diminishes over the hour, and you head home confidently to begin your own ERP.

As arranged, you call your therapist after three days of assignments to report on your progress and to see if you need to adjust the homework to help you succeed. "It was easier than I expected, but I still glanced back in the mirror several times each day. And I asked my wife for reassurance a few times when I got home," you acknowledge.

"That's good information," says your therapist. "Continue the exposure but really put the brakes on seeking reassurance. How about adjusting the mirrors at a slightly awkward angle – just enough to interrupt your reflexive checking? And work hard not to ask your wife for reassurance. How about if we invite her in to the next session so she can learn better how to help?"

At the next appointment, you and your wife discuss the impact of your OCD on you and the family. You and your therapist give your wife a summary of all you know about OCD and its treatment. "I understand that you reassure him so he'll feel better," your therapist tells your wife. "It may feel awkward at first, but the best way to help is to let him experience the anxiety that comes with exposing himself to his fears. That way he learns that he can handle them and that his fears are unlikely to come true." She helps you and your wife find some possible new lines: It sounds like your OCD is really getting to you, Those old OCD thoughts are getting stuck again, or It's hard to resist but you're really trying. She adds: "You might feel badly for him, or even get impatient for him to get better faster, but it's up to him. You don't need to be his therapist. All you can do is encourage him and step back."

When your wife leaves, you and your therapist modify your assignment to improve your compliance. "OK. I'll laminate little sticky-notes with the words, "It's not me, it's my OCD" and tape them to my car's rearview and side mirrors to make me more conscious of not checking them," you say. You also re-commit to zero tolerance of rituals or avoiding situations that bring up your obsessive thoughts. You're more successful this time, and when your anxiety diminishes with this task, you're ready to add a harder assignment that you craft with your therapist.

"Next I'm going to drive at least an hour a day in areas where I'll probably see pedestrians on the road," you summarize at the end of the next session. "I'm scheduling trips past schools at 8 a.m. and 3 p.m. and past crowds before and after sporting events. When the anxiety goes down with this assignment, I'll move up the list to a more challenging task: driving at dusk, when it's harder to see pedestrians and I get more anxious."

Within a month you are driving places you hadn't imagined possible without depending on your checking rituals.You're proud and feeling increasingly optimistic about your ability to control your OCD. But you want to make sure this isn't false confidence.

"I wonder if I'm calmer because I'm avoiding those scary thoughts that make me want to check and get reassured," you tell your therapist. "I know a way to find out," she says. So you add another layer of homework: mental exposure to the feared thoughts. She helps you write and then tape-record a script about a worse-case hit-and-run scenario.

You read it to her: "I hit a bump. I've run over a body. I hear a police siren. They're coming for me. I'm sweating as I pull over on the next block. I check the grill on my car: I see skin and can smell blood. I turn on the radio, already they're reporting my hit-in-run. I'm sure I'll go to prison." The story goes on.

You commit to spending an hour a day with twenty minutes each of reading the script, writing it out and listening to it. At first your anxiety spikes, but over time it becomes almost boring ("This is ridiculous; that just wouldn't happen!" you tell

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"The Aviator" – Howard Hughes vs. OCD

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tone for the whole film to follow and make the director's basic statement. Here was H. H. as a child, standing in a washtub, being bathed in an obviously seductive manner by his mother, as she warned him about the dangers of cholera and typhoid and pointed out the quarantine signs she had seen on some people's doors. As if to drive her point home, the mother also made him spell the word "quarantine" aloud. "Great," I muttered to myself, "Director Scorsese is already telling us that H. H.'s OCD has a psychological basis, and dear old mom was the cause. Just what we need – a pummeling with a full-strength dose of psychoanalytic claptrap to get things rolling." And this was just the first five minutes. I cringed in my seat, preparing myself for what was yet to come.

Then, surprisingly, things got better. The flirtation with antique psychological theory quickly passed, only to be referred to a few times in passing later on in the film. This film turned out to be a fascinating character portrayal, with some gripping moments arising not only from Howard Hughes' struggle with his disorder, but also from a life filled with epic attempts to surpass life's boundaries as well as the obstacles that were thrown in his path. With regard to these issues, one particularly strong theme that seemed to run through the entire movie and, actually, one that those unfamiliar with OCD might not pick up on, was Hughes' compulsive perfectionism. In lesser individuals, and those lacking the financial resources, this OC feature might not rise to the levels it seemed to in his case. Who else, regardless of cost, would have shot an entire movie ("Hell's Angels") twice, along with hundreds of hours of film that could never be shown, just to get it exactly right? It turned out to be the most expensive film ever created up to that time. Was this simply a case of high standards? "The Aviator" never exactly makes this clear. But let's face it – it was not meant to be a documentary on OCD. Clearly, Hughes was a brilliant, talented, nervy and single-minded individual, but my own suspicion is that Hughes' unrelenting standards frequently took him past the bounds of practicality or reasonableness, as it does in many OC sufferers. The film shows how his attempts at perfection certainly led him to some notable achievements – e.g., setting the world airspeed record and producing the largest airplane ever to fly; but the human and financial costs that these required seem totally out of proportion to anything lasting they may have produced. The film gives these perfectionistic quests of H. H. an air of heroism and nobility, but to me they still had the look of symptoms. Perhaps the average moviegoer would not have seen it in these terms.

As the film progresses, we also witness Hughes' descent into germ phobias and compulsive hand washing. Much to the film and actor Leonardo DiCaprio's credit, the portrayal of these behaviors had the ring of truth. As I said, I was expecting the worst, but ended up feeling that they got it right. Hughes was shown to carry his own soap (I don't know if he actually did this), to overuse hand towels in public restrooms, to scrub his hands till they bled, to avoid shaking hands whenever possible, and to reject an entire meal when someone touched the food on his plate, to name a few instances. Even the small detail of Hughes waiting inside a men's room for someone entering to open the door so he wouldn't have to touch the handle when he exited was dead on. "Yes," I said to myself, "this is what it can be like."

H. H. also had his enablers and, with his money, he could certainly afford to keep any number of them on his payroll. In addition, it would seem that the women in his life, who included movie idols, Katherine Hepburn and Ava Gardner, also took up the task of helping him in this way. While many OC sufferers will try to control those closest to them, as well as their environment, this was a case of pathology gone wild, an example of what can happen when a sufferer is given the unlimited resources that enable him/her to get really out of control with control. In what I thought was a really nice touch, the paradox of this type of control was also presented where Hughes' chief business rival uses the disorder against H.H. in an attempt to outmaneuver him for control of the international airline industry.

One other interesting and well-known aspect of Howard Hughes' personality, truthfully portrayed in the film, was his love of risk-taking. I have met a number of sufferers who have behaved in impulsive and even foolishly risky ways in areas of their lives outside of the risk-free zones they have tried to create as part of their OCD. In one instance in the film, personally testing a new plane he has designed nearly costs Hughes his life, not to mention permanently scarring and crippling him. While this may seem like a contradiction, in an OC sufferer the line between compulsivity and impulsivity can frequently be a thin one. Even compulsions, themselves, can, at times, be more hazardous and risky than the things they are supposed to protect against. This is also true for Hughes because the damage his compulsions do to his ability to function in his business and personal lives turns out to be far worse than the air crash.

On the minus side, one segment of the portrayal of Hughes' disorder did raise some questions for me as I viewed the film. As his contamination fears become increasingly severe, he is shown living naked in a locked room, looking like a wild man with long hair and nails, living on bottles of milk brought in according to a very specific set of rules, collecting his urine in the empty bottles, and repeatedly watching segments of films he had produced. This in itself was not unusual to me. Over the years, I have, on occasion, communicated with reclusive OC sufferers through locked doors, who lived in somewhat similar circumstances. What did not ring true for me was seeing Hughes suddenly rising from the midst of this and pulling himself together with the help of Ava Gardner (new suit, neat haircut, the works) in order to travel to Washington to defend his reputation and his airline before a hostile congressional hearing. I'm not saying this didn't happen; but in nearly 23 years of treating OCD, I have never seen anyone with symptoms that severe who was able to totally control their symptoms on short notice, and appear perfectly normal in a pressured public setting. If this portrayal is in fact true, then perhaps Howard Hughes was even more extraordinary than we have been led to believe.

One other puzzling aspect of the film, occurring several different times, was when Hughes is shown getting stuck repeating particular words or phrases dozens of times. Was this some type of verbal tic, or was it a perfectionistic attempt to say the words exactly right in some way? While the behavior clearly embarrasses Hughes, the film never explains what this is all about, and we are left guessing. The film actually ends with Hughes caught in one of these bouts.

All in all, I will say that "The Aviator" was worth the price of admission, and was one of the better portrayals of OCD on the big screen that has thus far been offered to the public. What could have been an exaggerated, sensational and disrespectful view of a larger-than-life individual's struggles with his own mind is actually a sensitive and insightful portrayal of a type seldom seen in film. While I cannot vouch for the historical accuracy, I can say that it is a well-crafted presentation, with extremely fine acting on the part of Mr. DiCaprio.

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OCD Treatment: Fighting Back

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yourself). Eventually you can drop it from your daily ERP tasks.

Now you're significantly less anxious during and after each trip out. Over the months you continue moving up the hierarchy to increasingly difficult tasks and learning how to master them. Still, your progress is uneven, depending on how stressful your life is and other occasional bumps.

"Sometimes I want to quit," you admit to your therapist at a session. "I'm so much better and sometimes I think I'd rather just accept my progress and make life easier by giving in to a few rituals when I'm having a bad day."

"I understand," she says. "Standing up to your OCD can be exhausting. And yet if you feed that hungry dog an occasional steak, do you think that would satisfy it?"

"No," you reply. "And honestly, that's what keeps me going when I'm tempted to take a break. That insatiable dog will always want more and I'm done being held hostage by it. I've gone cold turkey on my rituals and I'm committed to staying with this, but I'm going to need help."

Together you fine-tune your treatment plan to help you maintain your momentum and get the support you need. Your success motivates you and you continue to gain mastery over your OCD. The work is challenging and time consuming and you know you still have more work ahead of you. But your courage is bringing you a reward that is life-changing and indescribably sweet.

*** To protect confidentiality, case descriptions in this article are based on composite or fictionalized clients.**

Laurie Krauth, MA, is an Ann Arbor, Michigan psychotherapist specializing in cognitive-behavioral therapy with anxiety disorders, including OCD. She also treats depression and trauma and works with couples on relationship issues. Links to more information on the treatment of OCD and other mental health issues can be found at www.LaurieKrauth.com.

A Message From the President

(continued from page 1)

on the research that has been done at their site. As an observer during these discussions, I can tell you that it is both exciting and enlightening to listen to the dialogue that goes on in the room. It should also be noted that David Pauls, Ph.D., the chairman of the Collaborative and a professor at Harvard Medical School, submitted a request to the NIMH for financial support for the Genetics Collaborative's meetings. The request was granted. That will help us pursue our mission to support research in genetics, as well as in other areas pertaining to OCD.

Another subject that has been on my mind, and concerns other members of the OCF Board of Directors, is the ability to bring effective treatment to more people who are suffering with OCD. For years, I would sit at the Town Meetings at the Annual OCF Conferences and listen to people say again and again that there were not enough therapists trained in behavioral therapy in their home towns. The Foundation is looking into this problem. While we are exploring this issue, we decided to set up a Behavioral Therapy Institute Fund to help raise money to reduce the cost to participants. As you can well imagine, this fund is in its infancy stage. It will take some time to get it up and running. Meanwhile, our next Behavioral Therapy Institute will be at the University of Pennsylvania from April 29 to May 1, 2005. If you are interested in attending, please call Jeannette at the Foundation 203-401-2069.

Work on our Annual OCF Conference has also begun. If you have a suggestion for a workshop, or if you have any questions regarding the conference or want to discuss your proposal, you can contact Jeannette for that too. The Annual OCF Conference will be in San Diego, California, from July 29 to 31, 2005. I hope that you will be attending it. My whole family will be there again this year.

I would like to take this opportunity to wish you Peace in the New Year.

Best Regards,

Joy Kant
President
OCF Board of Directors

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