OCF Obsessive Compulsive Foundation

OCD Newsletter

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Self-Injurious Behavior

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Johnny Depp, Angelina Jolie, Winona Ryder, and Fiona Apple have been reported to engage in it. Television shows and movies, such as "Thirteen," "Seventh Heaven," "The Secretary" and "Girl Interrupted" have portrayed it. Writers Joyce Carol Oates and Sylvia Plath have written about it. Self injury, although certainly not a new phenomenon, has become a timely one. The increased media attention paid to self injury begs the question, "Has self injury always been around?"

Historically speaking, self injury is probably nothing so new. Primitive cultures, probably one of our best glimpses into the ancient world, are documented to engage in tribal scarification ceremonies at puberty. Because the first menstrual flow was viewed by the ancients as something magical (endowing a female with the ability to bear children), adolescent males began ritual genital bloodletting to mimic this significant rite of passage in females. A documented example of self injury dates back to 1789 from the crew of the British ship, *The Pandora*. The startled Englishmen witnessed Tahitian islanders surround *The Pandora* in canoes, stripping bare and bashing their heads with broken shells to display the grief that they felt at the recapture and seizure of the *Bounty* mutineers. Reportedly, the islanders thought that this display would somehow influence the crew of *The Pandora* to release the mutineers with whom they had intermarried and begun families (Alexander, 2003). Similar accounts can be found from a number of sailors to the Tahitian Islands in the 18th century. So, self injury does not seem to be a new behavior. However, could it be more common currently?

According to research, prevalence rates in the general population vary from 1 to 4 percent (Briere & Gil, 1998; Favazza & Conterio, 1989) but in a typical high school setting those statistics jump to 14 percent (Ross & Heath, 2002). This means that in a typical suburban high school of 1,000 children, 140 students may be self-injuring at any given time. The prevalence of self injury in clinical settings is even higher, with one study reporting that 40 to 60 percent of hospitalized adolescents in psychiatric settings were actively engaging in self injury (DiClemente, Ponton, & Hartley,

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Expenses for Mental Illness Must Be Covered in NY Health Insurance Policies

On December 23, 2006, Governor Pataki of New York signed into law a bill that requires insurance companies to provide equal coverage for individuals with mental illnesses. The bill is called Timothy's Law. It was named after Timothy O'Clair, a 12-year old boy from Schenectady County, who had an emotional disorder but was not able to obtain the necessary mental health services under his parents' health insurance policy. Timothy committed suicide in 2001 because he did not have the care he needed.

Timothy's Law mandates mental health parity. This means that adults and children with biologically based mental illnesses must receive the same health care benefits that an insured would be eligible for if s/he had a physical illness. Under the New York statute, insurers have to provide the same type and kind of inpatient benefits for someone with a biologically based mental illness as they would for someone with a physical illness.

And, the cost of any premiums and deductibles for treatment of a mental illness must be comparable to those set up for physical illnesses available under the same insurance policy.

Under Timothy's law, employers with 50 or more employees must include treatment for obsessive compulsive disorder as well as a number of other serious mental illnesses. Companies with fewer than 50 employees are required by this legislation to make equal benefits coverage for mental health services available for purchase upon request. The state of New York is going to provide financial assistance to small businesses that would have trouble paying for this type of coverage.

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Message From the President

Dear Friends,

As you have read in previous newsletters, the Obsessive Compulsive Foundation (OCF) is undergoing changes. Originating as a grass roots organization over twenty years ago, the OCF was founded by thirteen individuals with Obsessive Compulsive Disorder (OCD) who participated in the first successful drug trial at Yale University. Currently, we have over six thousand members, fifty practitioners comprising our Scientific Advisory Board, and a 4-member staff working out of the national office in New Haven, Connecticut.

In order to continue meeting your needs, the OCF Board of Directors hired Deidre Tavera of Deidre Tavera Consulting in April 2006 to do an organizational assessment of the Foundation. Initially, the Board of Directors were asked to complete a survey about the OCF and participated in one-on-one meetings with the consultant. Tavera also visited the OCF national office in Connecticut to meet individually with the staff and attended the national conference in July.

In early November, Tavera presented her initial findings to the OCF Board of Directors. The Board asked Tavera to continue working with the Foundation over the next year to develop a strategic plan. The planning process will include the development of an organizational vision for OCF, the creation of strategic priorities for the next 3-5 years and the establishment of goals,

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IN THIS ISSUE

Bulletin Board

Does Your Child Need to do Things Over and Over Again? Does He or She Have Recurrent and Bothersome Thoughts or Images?

Does your child repeatedly check or arrange things, have to wash his/her hands repeatedly, or maintain a particular order? Do unpleasant thoughts repeatedly enter your child's mind such as concerns with germs or dirt or needing to arrange things just so?

If this sounds familiar, your child may have a treatable problem called Obsessive-Compulsive Disorder (OCD). Past research has found that a form of cognitive therapy, called Exposure and Response Prevention Therapy, is helpful in as many as 85% of children with OCD. We are interested in determining if adding a medication called D-Cycloserine improves the effectiveness of Exposure and Response Prevention Therapy in children with OCD.

You must be between the ages of 8 and 17 years old to be eligible for this study. If you are eligible to participate in this study, you will be randomly assigned, that is by chance as in the "flip of a coin," to receive either the study medication (D-Cycloserine) or a sugar pill in addition to being seen in therapy. The therapy will be held weekly (90 minutes each session) for 8 weeks (10 total sessions). There will also be 3 psychiatric evaluations that take place. Two of these evaluations will be comprehensive and take about 3 hours each (immediately before and after treatment). During each of these, your child will have a small amount of blood withdrawn for lab tests. One evaluation will be short and take place in the middle of treatment. Study medication, treatment, laboratory tests, and the evaluations will be provided at no charge. Participants will also receive financial compensation for their time. If interested, please call Dr. Eric Storch of the University of Florida at (352) 392-3613.

Intensive CBT Training Workshops for Professionals

Cape Cod Institute, 2007
Presented by Aureen Pinto Wagner, Ph.D.

July 30 through August 3, 2007: **Cognitive-Behavioral Therapy for OCD and Anxiety: Effective and User-Friendly Treatment for Children and Adolescents.** This workshop is designed for clinicians and school personnel with beginner to intermediate experience in CBT. The focus is on the application of empirically-sound, developmentally sensitive and appealing CBT approaches that are feasible in clinical settings and designed to optimize motivation and treatment compliance in youngsters. Opportunities for learning will be maximized through clinical vignettes, video-taped demonstrations, case discussions, Teaching Tools and detailed handouts. Strategies for building treatment-readiness, collaborating with parents, managing anxiety in school, working with reluctant children, relapse prevention, and challenges in treatment will be discussed.

August 6 through 10, 2007: **Cognitive-Behavioral Therapy for OCD and Anxiety: Complexities and Challenges in Treating Children and Adolescents.** In this unique workshop, Dr. Wagner will cover anxiety-related topics that are not typically covered in depth in any single workshop. It is designed for clinicians and school professionals with at least intermediate experience with CBT, or those who have attended Dr. Wagner's previous workshops. The focus is on conceptualizing, strategizing and intervening with hard-to-treat and unusual symptoms, co-morbidities, overlapping symptom dimensions, and crisis-prone situations. Step-by-step clinical decision-making, selection and application of strategies through different phases of treatment will be reviewed. This workshop will integrate the science and the art of CBT, including the subtleties and the nuances of delivery and the complexities of the therapeutic alliance. Case discussions, video clips, "clinical pearls" and structured exercises will be woven through the workshop.

For more information or to register, please visit www.Cape.org or call 888-394-9293.

Wanted: Cognitive Behavior Therapist

The OCD Resource Center of Florida, specializing in the treatment of the OCD spectrum and anxiety disorders in adults and children, is seeking a bilingual (English/Spanish) licensed MSW or Ph.D./Psy.D. cognitive-behavior therapist. We are a busy private practice in South Florida that seeks to offer high quality clinical services out of our Miami office.

Preference will be given to candidates with beginning or advanced skills in cognitive-behavioral procedures used in the treatment of anxiety disorders in children and adults, especially exposure and response prevention for OCD. Strong communication/people skills, along with personal qualities of flexibility, reliability and compassion for psychiatrically disabled individuals is essential. Case supervision is available.

Please email or fax a cover letter, CV and three professional letters of reference to:
Bruce M. Hyman, Ph.D., LCSW, Director
OCD RESOURCE CENTER OF FLORIDA

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OCD NEWSLETTER

The OCD Newsletter is published six times a year.

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The Obsessive Compulsive Foundation (OCF) is a not-for-profit organization. Its mission is to increase research into, treatment for and understanding of obsessive compulsive disorder (OCD). In addition to its bi-monthly newsletter, the OCF's resources and activities include: an annual membership conference, web site, training programs for mental health professionals, annual research awards, affiliates, and support groups throughout the United States and Canada. The OCF also sends out Info Packets and Referral Lists to people with OCD, and sells books and pamphlets through the OCF bookstore.

SELF-INJURIOUS BEHAVIOR

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1991). These statistics suggest that self-injurious behavior deserves some serious attention.

"Self injury," is a broad term that can refer to a variety of behaviors associated with a variety of reasons. It is used interchangeably with "self-harm," "self mutilation," and "cutting." The general public is most familiar with the "impulsive" and "compulsive" forms of self injury, which differ based on the motivation for the behavior and the diagnoses with which they are associated.

Impulsive self injury is defined as a direct, intentional, repetitive behavior resulting in mild to moderate physical injury (Suyemoto, 1998). Although cutting is the most common method of impulsive self injury, other methods include hitting, burning, pinching, puncturing, and interfering with wound healing (picking). The most common reason for impulsive self injury is an attempt at emotion regulation. In essence, the individual engaging in self injury is attempting to down-regulate intense or painful emotions. Self injury is often reported to impart a sense of calm and relief because it leads to the production of endorphins (think "runner's high") in the brain. The problem with this behavior, apart from the fact that it is physically dangerous and maladaptive as a coping style, is that it can eventually become biologically addictive.

In addition to emotion regulation, impulsive self injury is also often a way to: (1) communicate painful emotions that are difficult to express ("I'm overwhelmed by self-loathing."), (2) communicate interpersonal boundaries ("Stay away from me; I'm dangerous!" or "Get closer to me; I need help."), (3) to seek attention or help ("Help, I'm feeling ignored, abandoned, rejected."), (4) to test others' devotion ("Will you still love and care for me even if I'm doing this to myself?"), (5) to punish oneself or others (I'm punishing myself because I'm inadequate, unworthy, unlovable." or "I'm punishing you because you hurt me."), or (6) to feel something when one feels numb. Impulsive self injury is often associated with borderline personality disorder, dissociative disorders, post-traumatic stress disorder, a history of sexual abuse, depression, bipolar disorder, and eating disorders. Rates of self injury in those diagnosed with borderline personality disorder can be up to 80 percent!

Compulsive self injury often includes skin picking, nail biting, and cuticle picking. These behaviors are usually seen within the obsessive compulsive spectrum disorders and are seen as "habit" behaviors. They are usually repetitive and may or may not be under the person's conscious awareness. In the case of body dysmorphic disorder, self injury is most likely a way to correct or improve appearance, usually skin "imperfections."

At first glance, these two forms of self injury may appear to be separate and distinct, but a closer look reveals many similarities. Many individuals who engage in impulsive self injury often do it in a "ritualistic" manner, using the same tools and the same location in the same way as a person with an obsessive compulsive spectrum disorder engaging in rituals. Individuals with OCD, trichotillomania, and BDD, on the other hand, will often report skin picking, hair pulling, or nail biting in response to painful negative emotions or situations, such as anger and sadness in a manner similar to impulsive self injurers. Our patients with trichotillomania describe hair pulling, cuticle picking, or nail biting as a habit behavior but it is sometimes used as an effective means to deal with negative emotions. Even patients with BDD who "self injure" in order to improve their appearance, describe that the picking, tweezing, etc., was an effective way to numb or escape their day. Similarity, our OCD patients who skin pick to achieve smoothness, not for the sake of improving physical appearance, but simply to achieve perfect smoothness also state similar experiences when picking. Many patients have described "going into a trance" when they pick. They report looking forward all day to going home just to be in front of the bathroom mirror because it was the only thing that provided a sense of relief.

Another compelling similarity between impulsive and compulsive self injurers is the drive for perfection. We tend to think mainly of perfectionism in relation to OCD, BDD, eating disorders, and depression; but many impulsive self injurers are also perfectionistic. Similar to individuals with BDD and OCD, impulsive self injurers also believe that unless they act, look, or perform perfectly, their lives and/or relationships will be failures. When perfectionists fail to achieve perfection (such as earning a 94 instead of a 100 on a test), they consider it a failure. When one's standards are so unrealistically high, a slight misstep leaves one with miles to fall. Those falls are often punished with relentless psychological self-flagellation, which may eventually become physical. When it does, it can manifest as self injury. This concept is nothing new. In fact, St. Thomas Aquinas engaged in relentless corporal mortification (body punishment through a variety of brutal means, including actual flagellation or whipping) as a result of his imperfect or "unclean" thoughts. Most self injurers, however, are not canonized!

Treatment for both forms of self injury requires a comprehensive cognitive behavioral approach. In the case of impulsive self injury, a variation of cognitive behavioral treatment developed by Marsha Linehan called dialectical behavior therapy (DBT), that in addition to standard CBT techniques, is useful. It has specific elements to help individuals deal with mood lability, improve tolerance for negative emotions, teach skills to improve interpersonal interactions, deal with chronic suicidality, as well as self-injurious behavior. DBT therapists attempt to achieve a balance between acceptance and change in the therapeutic process. DBT, however, is not only useful for impulsive self injurers. When we help a patient with self-injurious behavior, whether of the impulsive or compulsive type, we use a combination of treatment strategies in conjunction for the most beneficial outcome. For example, in treating a patient with OCD who is skin picking bumps on his/her arm, we would first aim to identify which situations, thoughts, or emotions trigger the urge to pick (such as feeling his/her skin for bumps, experiencing a particularly stressful day, an argument with a spouse, hunger, fatigue, etc.) to increase awareness of the picking behavior. We would also target the maladaptive beliefs that maintain the behavior, such as the belief that one's skin should be "perfectly" smooth or the belief that it is possible to pick "just one" blemish and then stop. In addition, we would also incorporate exposure and response strategies by deliberately creating an urge to pick, perhaps by instructing the patient to feel his/her arm for bumps, and then practice response prevention (not picking). We may also teach DBT-based self soothing strategies for coping more effectively with negative emotions so that our patient didn't feel the need to turn to self injurious behavior for relief of emotions. In the case of an impulsive self injurer, the treatment is also quite similar and incorporates all of these techniques.

We also make a conscious effort to include family members in the treatment process. Family involvement can have a great impact on a person's treatment progress. Therapists have limited contact with their patients whereas the family has the luxury of seeing the patient under a variety of circumstances and is an incredible source of information for therapists. So if you are a family member, don't feel obligated to sit silently in the waiting room week after week reading a magazine while your daughter, son, spouse, etc. is in the session. Ask to be involved. Your involvement will help your family member and you. The degree of your involvement, however, will vary based on the stage of treatment, the therapist's style, your family member's comfort level with your involvement, etc. We routinely aim to teach family members how to respond when their child comes to them with an urge to harm her/himself, how to validate emotions, maintain healthy boundaries, and take care of their own emotional needs. Perhaps our most important message to sufferers and family is that there is hope. Treatment advances offer effective strategies for self injury and we hope that many more are on the way!

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Need to Know OCD

By William M. Gordon, Ph.D.
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What's under that carpet? Who's on Dave Letterman tonight? What's inside of that paper cup on the side of the road? What's the name of that tune on the radio? What's inside the wall? What's the name of the bus boy? All of these questions are innocuous enough when considered separately. However, when they become part of a chronic pattern that consumes hours of time every day, they are no longer so innocent. They become symptoms of a relatively uncommon type of OCD called "Need to Know OCD." Although it is a less discussed form of OCD, it still can teach us a lot about OCD in general.

Unlike idle curiosity, "Need to Know OCD" (NTK-OCD) demands an answer. It has a driven, compulsive quality that is disruptive and distressing. It differs from healthy curiosity in that the person with NTK-OCD has no genuine interest in the content of the question. Instead, the individual finds himself compelled to acquire useless, pointless knowledge. Like most other forms of OCD, NTK-OCD is a two-part procedure with an obsession and a compulsion. The obsession is usually in the form of a question. The compulsion is all subsequent behavior performed to answer the question. We can say then that there is a question and a quest. The quest, i.e., the compulsion, consists of overt and mental rituals. The overt rituals are the research done to get the answer. The person might ask other people, eavesdrop, make phone calls, look in the newspaper, or search the Internet. The mental rituals consist of wracking one's brains to try to remember or imagine the correct answer.

Interestingly, NTK-OCD usually has no connection to danger, aggression, safety, religion, or sexuality. The missing information generally is rather boring. There is no imagined external threat or lurking catastrophe for the individual or his or her loved ones, as in the classical obsessions. Still, the person feels driven to find the answer. The acquisition of the answer immediately quiets the distress and unsettled feeling. The person feels normal again and able to resume other activities. As in other forms of OCD, the sense of relief after performing the compulsion reinforces the tendency to believe that rituals are necessary to feel okay. By performing the rituals, i.e., by desperately seeking to answer the obsessive question, the person never finds out that the sense of urgency will decay naturally. Most people suffering from this type of OCD will admit the next day that the question has lost its appeal whether answered or not. Yet even with good insight, it remains very difficult to resist its initial lure.

By trying to answer the question, its presumed importance actually increases. Patients report that their distress rises and their self control falls as they focus on it and begin trying to get the information. They get sucked into an OCD whirlpool. Thus, it becomes critical to avoid the entire process. I tell people, "Don't react to the urge. Nip it in the bud." Otherwise too much obsessive thrust is generated to resist. This principle, that it's easier to resist an obsession in its early stages, applies to other types of OCD as well.

When I ask patients why they try to answer these silly questions that they know will generate an OCD loop, they mention their fear of OCD itself. They are frightened that if they ignore the question, it will come back to haunt them. They are scared that they might start to obsess about it later on. It seems easier to get the answer right away than to face the possibility of wanting to answer it later and not being able to. Thus, the compulsive search is done not just to quiet the initial distress but also to prevent future distress. This assumed preventative function of the compulsion occurs in most other forms of OCD too. (For example, a person might spend five minutes every night checking to see that the toilet seat is in the down position. He does it not to avoid germs or urine but to avoid the possibility of being worried about it later at night.) The irony of course is that the person ends up ritualizing in order to avoid ritualizing. Ritualizing then becomes a preferred coping strategy which generalizes to new areas. The individual then feels less able to ignore later obsessions.

One can compare NTK-OCD with hoarding. In both instances, people amass useless junk. With hoarders, it's actual objects or "stuff." With NTK-OCD, it's information. Unlike hoarders, people with NTK-OCD do not have an emotional attachment to the information. Once acquired, it loses its value. Its sole value is in being able to calm the person by quieting the obsession. Occasionally, though, people might take notes to save the information for future use.

In treating NTK-OCD, its seeming innocence can become an obstacle. After all, what's the big problem in asking that bus boy his name? Why not ask a few people to help identify that tune on the radio? Isn't it easier to ask one question now than to worry about it later on? All of these rationalizations ignore the fact that OCD feeds on itself. The more you do it, the more you want to keep doing it. It's like eating potato chips.

Another problem in the treatment of NTK-OCD is its widespread, pervasive nature. Every day there are hundreds if not thousands of unknown pieces of information that can be sought. Trying to resist all of them can be overwhelming. "Why fight one when so many others will be there to replace it?" It can seem futile. To counter this reality, it helps at first to concentrate on resisting one well-defined area. For example, you might start out trying to focus only on unknown melodies. Then you could broaden your resistance to include names of men or of women. Very gradually, you expand the range of items you can ignore. By working slowly you avoid getting discouraged and you start to build up confidence in your ability to fight OCD.

Exposure and response prevention (ERP) is used to help people get used to ignoring common triggers. In using ERP, you purposefully try to engineer situations where there's missing information. An example would be to deliberately turn off the TV before finding out who said something. Then, of course, you need to refrain from seeking the information by other means. Doing these exposures repeatedly helps you resist these triggers when they occur naturally. It teaches you that obsessions erode spontaneously without the need for you to do a thing.

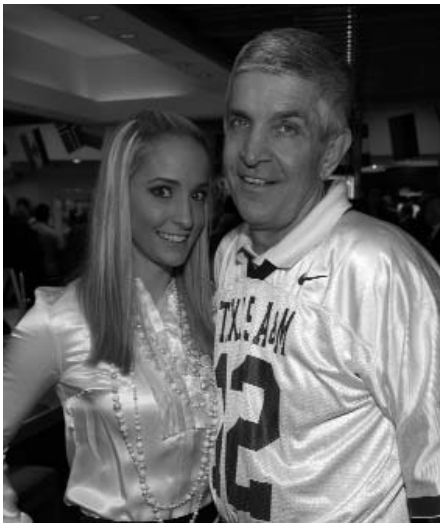
NTK-OCD can be episodic and unpredictable. You can be going along quite well for a few weeks and then suddenly feel tremendous urges to search out junk information. At times like that, remember that these new urges, too, will pass. Discussing the upsurge with a knowledgeable friend, therapist, or support group can also be helpful. Treating OCD can be difficult; not treating it is even more difficult. So persevere and stay strong.

Dr. Gordon can be reached at 973-744-8791.

Anniversary Celebration Raises Money for OCF Research Fund

As part of its 30th Anniversary celebration, Zadok Jewelers in Houston, TX, held a raffle for the OCF's Research Fund. The party was held at Zadok's store on November 29, 2006 and topped off a day of celebration that included trunk shows by important jewelry designers. More than 400 people attended the day-long event. Members of the Zadok family who took part in the anniversary celebration were Helene, Dror, Jonathan, Gilad, Amy and Segev (see picture above).

The Zadok family (left to right) Gilad, Jonathan, Helene, Dror, Amy and Segev Zadok



Liz McIngvale with her father, James McIngvale

The theme for the anniversary celebration was "The International World of Jewelry." To bring this theme alive, there were international decorations, costumed mannequins and food stations that reflected the theme with Asian, Mediterranean, Middle-Eastern and down-home Texas food. There was an Italian gelato stand from the Coffee Groundz. There was also a band providing live music.

Liz McIngvale, OCF National Spokesperson, with Raffle winner Philip Brown and Dror and Helene Zadok

Philip Brown, raffle winner

The raffle was unique. Guests at the party bought keys at the cost of $50.00 apiece. The keys were to unlock various "treasure chests" that contained different pieces of jewelry donated by Zadok's vendors. There were 16 prizes awarded. Among the prizes were an 18k yellow gold and diamond necklace from Carrera y Carrera that was valued at $7,400.00 and a Jaeger-le Coultre watch worth $7,500.00.

Liz McIngvale, the OC Foundation's spokesperson in its Public Awareness Campaign, made a guest appearance representing the OCF. She helped give out the raffle prizes. Through the raffle, the Zadoks were able to raise almost $8,000 for the OCF's Research Fund.

Research Di

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

This Research Digest focuses on OCD in children and adolescents. We begin by repeating the seminal POTS paper that already showed the persistence of untreated OCD and the progressively greater benefits of medication, cognitive behavior therapy (CBT) and their combination. Elaborations on this theme are presented in studies of CBT and medications in youngsters with PANDAS. Importantly, CBT was effectively guided by a manual outside expert research settings. Finally, for emphasis, we summarize the article that defined the small but measurable risk of increased suicidal thoughts and behaviors (suicidality) early in treatment. These findings have recently been extended to antidepressant users up to age 25. Beyond age 25, antidepressants were found to decrease suiciality early in treatment. Lots of acronyms above. Read below and they all will be revealed (JHG).

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

This landmark Pediatric OCD Treatment Study (POTS) compared 4 treatments for children and adolescents with OCD-cognitive-behavior therapy (CBT) alone, medication treatment alone (sertraline [Zoloft]), combination CBT with sertraline, and pill placebo treatment. Randomly assigned to one of the four treatment groups, 112 child and adolescent patients (aged 7 to 17 years) participated in the study. Combined treatment was superior to CBT alone and to sertraline alone, and all active treatments were significantly more effective than placebo. Response rates for the four treatments were 53.6% for combined CBT and medication, 39.3% for CBT alone, 21.4% for sertraline alone and 3.6% for placebo. In accordance with published guidelines, researchers concluded that children and adolescents with OCD should begin treatment with the combination of CBT plus a selective serotonin reuptake inhibitor (SSRI) or CBT alone.

An open clinical trial of cognitive-behaviour therapy in children and adolescents with obsessive-compulsive disorder administered in regular outpatient clinics

Behaviour Research and Therapy, Epub ahead of print, 2006, R. Valderhaug, B. Larsson, K.G. Gotestam and J. Piacentini

Research studies have demonstrated the effectiveness of cognitive-behavioral therapy (CBT) in treating childhood OCD. However, the majority of studies have taken place in highly specialized university clinics with above average experience in the treatment of OCD. This study addresses the question of whether CBT will be equally effective in regular clinic settings. At three non-academic outpatient psychiatric clinics in Norway, 28 children (aged 8-17 years) entered this study and 24 (86%) completed treatment and were available for follow-up assessments. Therapy consisted of 12 manual-guided sessions with combined individual and family CBT-based interventions. The program was based on an unpublished manual developed by John Piacentini, Ph.D., and others from the UCLA Anxiety Disorders Clinic, Los Angeles, California. Dr. Piacentini provided training and supervision for the project. Defining response as a 50% or greater reduction of symptoms as measured by the Children's Yale-Brown Obsessive Compulsive Scale, 18 patients (75%) had responded at the end of treatment, this decreased to 16 patients (66.7%) at 3-month follow-up and increased to 21 patients (87.5%) at 6-month follow-up. Manual-guided CBT for childhood OCD can be successfully implemented in non-academic community psychiatric settings with outcomes similar to findings from highly specialized university clinics.

Peer victimization in children with obsessive-compulsive disorder: relations with symptoms of psychopathology

Journal of Clinical Child and Adolescent Psychology, 35:446-455, 2006, E.A. Storch, D. R. Ledley, A.B. Lewin et al.

How children get along with other children, their peers, is important in their social and emotional development. Peer victimization is a form of peer maltreatment in which a child is targeted by a peer or group of peers. This study examined frequency and psychological effects of peer victimization in children with OCD. Using several questionnaires, 52 children with OCD were compared to 52 children with diabetes and 52 children without mental or physical illnesses. Children with OCD reported higher rates of peer victimization in comparison to reports by children with diabetes or healthy controls. Over 25% of children with OCD reported being victimized regularly by their peers. Peer victimization in the OCD group was associated with loneliness, depression symptoms, severity of OCD and parent reports of child behavior problems. In addition to treatment of OCD, authors suggest children would benefit from interventions, such as social skills training, to help them succeed in their social world.

PANDAS: to treat or not to treat?

Advances in Neurology, 99:179-183, 2006, R.A. King

Streptococcal infections can trigger onset or worsening of OCD and tic disorders. This subtype of OCD is referred to as PANDAS (pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections). PANDAS is identified by five criteria: presence of OCD and/or tics; childhood onset; acute, severe onset or dramatic symptom worsening and an episodic course; neurological abnormalities present during worsening of symptoms; and a temporal association between streptococcal infection and symptoms. Dr. King provides treatment guidelines and discusses difficulties in diagnosing and treating PANDAS. At this time, clinicians should obtain throat cultures of children with abrupt onset or dramatic worsening of OC/tic symptoms and should treat positive throat cultures with standard 10-day antibiotic treatment. Long-term prophylactic antibiotic treatment should be reserved for children with a clear history of recurrent abrupt exacerbations of OCD linked to streptococcal infections, keeping in mind the danger of creating future antibiotic resistance. Immunomodulatory treatments, plasmapheresis and intravenous immunoglobulins, are complicated unproven treatments and have side effects. These treatments should only be used in research settings and currently the author is unaware of any active clinical trials.

Cognitive-behavioral therapy for PANDAS-related obsessive-compulsive disorder: findings from a preliminary waitlist controlled open trial

Journal of the American Academy of Child and Adolescent Psychiatry, 45:1171-1178, 2006, E.A. Storch, T.K. Murphy, G.R. Geffken et al.

Seven children with OCD of the PANDAS

gest

subtype were treated in a 3-week intensive cognitive-behavioral therapy (CBT) program. Six of the 7 children responded. This study provides preliminary support for CBT in treating the PANDAS subtype of child OCD. Although CBT may not prevent future episodes of streptococcal-triggered episodes, CBT gives the family and child the skills needed to lessen the severity of future episodes.

Selective serotonin reuptake inhibitor-induced behavioral activation in the PANDAS subtype

Primary Psychiatry, 13:87-89, 2006, T.K Murphy, E.A. Storch and M.S. Strawser

Selective serotonin reuptake inhibitors (SSRIs) are effective and commonly used in treating OCD in children. However, SSRI medications have side effects and children with PANDAS may have increased vulnerability to SSRI-induced behavioral side effects. Researchers presented data on behavioral activation following SSRI treatment of 38 children with OCD of the PANDAS subtype. Behavioral activation symptoms included hyperactivity, mania, disinhibition, worsening of obsessions or compulsions, aggressiveness, irritability, agitation and suicidal thoughts. A case report is used as an example of increased behavioral activation with SSRI treatment and to emphasize that OCD may be successfully treated with lower doses of SSRIs. The message to physicians is to use lower dosing of SSRIs in the OCD subtype of PANDAS and to monitor closely for behavioral side effects.

Suicidality in pediatric patients treated with antidepressant drugs

Archives of General Psychiatry, 63:332-339, 2006, T.A. Hammad, T. Laughren and J. Racoosin

There is concern that antidepressants can cause suicidal thoughts or increase the risk of suicide in children. The United States Food and Drug Administration (FDA) investigated the occurrence of suicidal thoughts or behaviors in data from 4,582 children and adolescents who participated in 24 trials of 9 antidepressants. The data included 4 OCD treatment studies. There were no completed suicides in any of the studies. The use of antidepressant drugs was associated with a modestly increased risk of suicidal thoughts or behavior (suicidality). The risk of suicidality was calculated as the difference between risk in the drug group and risk in the placebo group, with the overall risk being .02. This means that in 100 treated patients, 1 to 3 patients would have an increase in suicidality beyond the risk that occurs with depression itself. The FDA now requires a boxed warning with all antidepressant drug labeling. The FDA has not contraindicated any antidepressant, but advises close monitoring of patients as a way to manage potential risk of suicidality.

Listed below are resource books on childhood OCD:

Freeing Your Child From Obsessive Compulsive Disorder. Chansky TE. Three Rivers Press, New York, 2000

Helping Your Child with OCD: A Workbook for Parents of Children with Obsessive-Compulsive Disorder. Fitzgibbons L, Pedrick C. New Harbinger, Oakland, CA, 2003

Obsessive Compulsive Disorder in Children and Adolescents: A Guide. Johnston HF, Fruehling JJ. Rockston, Ink and Madison Institute of Medicine, Madison, WI, rev. ed., 2002

OCD in Children and Adolescents: A Cognitive-Behavioral Treatment Manual. March JS, Mulle K. Guilford Press, New York, 1998

Treatment of OCD in Children and Adolescents: A Cognitive-Behavioral Therapy Manual. Wagner AP. Lighthouse Press, Rochester, NY, 2003

What to Do When Your Child Has Obsessive-Compulsive Disorder: Strategies and Solutions. Wagner AP. Lighthouse Press, Rochester, NY, 2002.

Help Find A Cure. Donate to the OCF Research Fund.

MESSAGE FROM THE PRESIDENT

(continued from page 1)

objectives and realistic timelines to meet those priorities. After the board meeting, Tavera met with Patricia Perkins, the OCF Executive Director, and the staff to review the organizational structure of the national OCF.

Bruce Putterman, a Marketing-Communications and Research Specialist, will be working alongside Tavera for the remainder of the project and will focus on the OCF community. As the Board develops the strategic plan, the viewpoints and the perspectives of our consumers are vitally important. The research component of the planning will include surveys and interviews with key members of the OCF community including the Scientific Advisory Board, affiliates, support groups, members, treatment providers, and others. We will assess the perceptions of OCF, satisfaction levels and unmet needs.

In January, Tavera and Putterman led a three-day strategic planning retreat for the OCF Board of Directors and the national office staff. During that time, retreat attendees reviewed the 1986 mission statement, assessed the opportunities for the OCF's future and how the Foundation would achieve its goals.

Throughout the yearlong strategic planning process, the Foundation will be assessing current and prospective "consumers" and the value of the OCF to each customer group. The OCF will determine critical success factors to measure in the upcoming year, in five years, and in ten years. Strategic priorities will be established in all key areas of the organization: programs, fund development, marketing and communications, finance, operations, governance, and legislation.

Tavera and Putterman will conduct in-depth individual phone interviews with the affiliates, brief phone interviews (or email surveys) with selected support group representatives and others in the OCF community.

If you are an OCF member, treatment provider, or another consumer of our services, you will soon be asked to assess the Foundation through an on-line "survey monkey". If you have additional information not addressed by the survey, you may contact Deidre Tavera at dmt@snet.net. Currently, for the 2007 OCF Annual Conference, we are considering small focus groups to allow stakeholders to share their views and goals for the OCF.

This is a very exciting time for the Foundation. We welcome your feedback so that we may continue to provide you with comprehensive support, guidance, and information regarding OCD. May we all look forward to a bright new year.

Best Regards,

Joy Kant
President of the OCF Board of Directors

An Interview with the Direct Program at Western Psych

The following is an interview with Robert Hudak, M.D., about the Intensive Outpatient Program at Western Psychiatric Institute and Clinic. This interview is an update of the profile done in 2001.

NEWSLETTER: We first profiled the Center for Treatment of OCD at Western Psychiatric Institute and Clinic in Pittsburgh in 2001. What can you tell us about the program now?

HUDAK: Western Psychiatric Institute and Clinic (WPIC) is a hospital of the University of Pittsburgh Medical Center (UPMC). WPIC has been recognized as one of the top 10 behavioral treatment providers in the country by "U.S. News and World Report." The OCD Program offers outpatient treatment for people with OCD as well as people with related spectrum disorders, such as social anxiety disorder or body dysmorphic disorder. The program that we offer is an Intensive Outpatient Program (IOP). What this means is that people receive treatment on an outpatient basis with us three days a week. Each daily session lasts three hours. The typical length of treatment in the program is about six to eight weeks. The treatment is run in a group setting, although individuals may have one-on-one time with a therapist during exposure therapy work.

Clients are assigned a primary therapist who will work with them during their time in the program. The therapist will work closely with the patient to design an appropriate exposure therapy treatment, then will work with him/her to do the exposures to the feared obsessions. Clients learn to function on their own as they progress with exposures to acquire the ability to work without the direct support of a therapist. This includes performing homework exposures and then following up with less intensive outpatient treatment after discharge from the program.

NEWSLETTER: How is regular outpatient therapy arranged after discharge from the Intensive Outpatient Program?

HUDAK: At this time, the WPIC OCD program does not directly offer regular outpatient behavioral therapy. When patients are discharged from the IOP, they are referred to an outpatient provider. Fortunately, we are lucky in Pittsburgh, because we have trained many therapists through our program that now work in the community. Many of these therapists have years of experience in the treatment of OCD and in the WPIC OCD IOP. As a result, we have a large referral base of experienced clinicians whom clients can see on an outpatient basis.

Patients who need further medication management are able to continue to see the IOP psychiatrist on an outpatient basis if they desire. The psychiatrist will work with the therapist in the community to ensure that an appropriate treatment plan is coordinated.

NEWSLETTER: What treatment modalities are used at the Center for Treatment of OCD?

HUDAK: The Center for Treatment of OCD uses evidence-based treatment. The primary modalities are Exposure and Response Prevention (ERP) therapy, and medication therapy. Some clients with OCD, particularly people with milder cases, may choose to do therapy exclusively without using medications. These individuals are offered medication consultations as well in order to help them make an informed decision. For people with more severe OCD symptoms, exposure therapy can be very challenging, and medications are offered to these clients because we feel that this leads to greater efficacy of the behavioral treatment intervention. Other treatments utilized are cognitive behavioral interventions targeting co-morbid disorders, such as depression and other anxiety disorders.

NEWSLETTER: Who are the treatment providers at the Center and what are their backgrounds?

HUDAK: Me for one – Robert Hudak, M.D. I have been the Medical Director of the Clinic since 2000, and I am an Assistant Professor of Psychiatry at the University of Pittsburgh Medical School. I graduated from the Northeastern Ohio Universities College of Medicine in 1992, and did my psychiatry training at Case Western Reserve University where I also held a faculty appointment as Assistant Professor of Psychiatry before coming to Pittsburgh. I was also the Medical Director of the OCD Outpatient Clinic at the Cleveland VA Medical Center from 1997-1999.

Terrie L. Means, Licensed Clinical Social Worker, is the senior clinician at the OCD Clinic. She has been with the clinic since 2002. Terrie received her Masters of Social Work degree from the University of Pittsburgh. She is also currently a Ph.D. candidate at The Institute for Clinical Social Work in Chicago, IL. In addition to co-facilitating the OCD IOP, Terrie has experience with conducting groups for GAD (General Anxiety Disorder), Panic Disorder and Social Phobia. She also has experience treating children with OCD and anxiety disorders. Her private practice consists of adults and children. Terrie was instrumental in aiding Dr. Andrew Gilbert, M.D., and his staff at WPIC Child's OCD IOP. She also is the supervisor for the interns joining the program.

Lynn Farbotnik, Licensed Clinical Social Worker, joined the staff at the OCD Clinic in the summer of 2006. For the past two years, she has been working in the WPIC Mood Disorders Intensive Outpatient Program where she gained experience with teaching Dialectical Behavior Therapy skills (DBT). Lynn has also worked as an inpatient Social Worker and Milieu Therapist at WPIC, and she worked on the General Adult Inpatient Unit. Lynn received both her Bachelor's Degree in Psychology and Master's Degree in Social Work from the University of Pittsburgh.

In addition to our full-time staff members, we utilize psychiatric residents from the University of Pittsburgh psychiatric residency program to provide both medication management and behavioral therapy. The psychiatric residents are directly supervised by me in

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the medical management of OCD. We also utilize interns from the University of Pittsburgh School of Social Work and from WPIC's doctoral Clinical Psychology Internship Program. All of our interns and residents have training in ERP and work under the supervision of the full-time staff members.

We consider our interns and residents to be a key component of our program. The interns and residents allow us to treat a larger number of clients than we otherwise would be able to. In addition, because of the extensive training that they receive, we are gratified to know that every year we add several clinicians to the local and national community of competent OCD treatment providers.

NEWSLETTER: How are people referred to the Center?

HUDAK: Many of our clients are self-referred. They often hear about our program through community support groups or through the local OCF affiliate. We also have a large number of clients who simply found out about us via the internet.

Other referrals come through local mental health professionals. When someone is referred by his/her own therapist or psychiatrist, we will provide a thorough consultation for the patient including both medication and behavioral treatment. When the client is done with our Center, we will coordinate with the client's primary behavioral team so that they are aware of our recommendations.

NEWSLETTER: Why does the Center focus on intensive outpatient therapy for its behavioral treatment?

HUDAK: We feel that most people with OCD, whether their illness is at the mild, moderate, or severe level, can benefit from the intensive outpatient level of care. While many people will do well with the traditional level of outpatient therapy, because intensive outpatient therapy is so effective, we feel that it should be presented as a highly recommended treatment option.

NEWSLETTER: Is your OCD program for adults only, or do you treat children and adolescents as well?

HUDAK: We usually do not treat children, but instead refer them to our sister program, the WPIC OCD IOP for Children and Adolescents. It is specifically targeted to children. In the case of patients who could fit into either program, such as a 17 year-old who has graduated from high school, we work with the child program to determine which program, either the adult or child, is the best placement.

NEWSLETTER: What activities and treatments does your OCD program include?

HUDAK: Because we see clients in the IOP for only nine hours a week, we spend most of the time doing ERP. This includes preparing clients for behavioral treatments, discussing exposure and response prevention homework and exposure work, both imaginal and ***in vivo***.

NEWSLETTER: How many participants can you accommodate in your program?

HUDAK: The Center will only take the number of clients that can be appropriately treated with our available staff. Usually, what this means is that we will accept a maximum of eight clients at anyone time. If necessary, we will maintain a waiting list of clients to admit to the program. However, we work to ensure that the wait time to get in is as short as possible.

NEWSLETTER: Is your program covered by private insurance?

HUDAK: Yes, most insurance plans will cover our intensive outpatient treatment. We contact the insurance companies for pre-authorizations and maintain contact throughout treatment to ensure that continued authorizations are obtained.

NEWSLETTER: Do you have any programs for individuals who are treatment refractory?

HUDAK: Many of our clients come to our program with that label, yet they do rather well. For people who do not improve sufficiently, we will allow them to stay in the program longer when that is felt to be necessary. If an individual needs other levels of care due to more refractory symptoms, we are willing to refer. We are in contact with other OCD treatment centers, and we will refer someone for inpatient or residential treatment if it is needed.

NEWSLETTER: What follow-up does the program offer?

HUDAK: Patients who do not already have a primary psychiatrist have the option of staying in medication management with me or the resident psychiatrist that they saw in the program. I maintain supervision of any of the residents who see our OCD clients. We also refer to outpatient therapists in the community, many of whom trained and/or worked in the OCD treatment center. In addition, there are many support groups that our former clients tend to find very helpful, including a local GOAL group.

NEWSLETTER: Does your program accept people with multiple diagnoses? Can someone be accepted if they have a substance abuse problem or a co-morbid condition?

HUDAK: There are no exclusions based on having problems other than OCD. Occasionally, the presence of co-morbid conditions can interfere with behavioral treatment. This may necessitate that treatment for these other problems occurs first. We have treated successfully many individuals with co-morbid conditions, such as schizophrenia, bipolar disorder, other anxiety disorders, and depression. Sometimes people are too depressed to benefit from behavioral treatment of their OCD and will do better once their depression begins to lift. However, if someone has the ability to work on both conditions at once, we will treat those individuals in the OCD IOP.

NEWSLETTER: If someone is interested in the Center's program, how do they get more information?

HUDAK: Our clinic phone number is 412-586-9222. We will talk with the interested person and give him/her information so that s/he may better understand the illness, the treatment,

How Do I Know Wheth Straight or Gay? An U

By Fred Penzel, Ph.D.
Western Suffolk Psychological Services
Huntington, NY

Over the years, I have written quite a number of articles about different forms of OCD. Because the variations are endless, there always seemed to be a great hunger for information on the part of sufferers trying to understand what is happening to them, specifically. Interestingly enough, the article that has always generated the most emails and phone calls is one entitled, "How Do I Know I'm Not Really Gay?" The OCF published this in its newsletter in 1995. Back when I wrote that article, it was my belief that although no one had ever written about it, this form of the disorder was far more prevalent than most people realized. The twelve years since then have convinced me even further that this is so.

Fortunately for sufferers, the general awareness of this type of OCD has increased over the years, and there is less of a sense of isolation than formerly. There are now several Internet chat groups and bulletin boards that can be readily accessed, and a quick web search will turn up articles on the subject where none existed in the past. Within my own practice, there is rarely a time these days when I am treating fewer than six or more people for this form of the disorder. I think it would be reasonable to say that after all this time an update is in order.

OCD, as we know, is largely about experiencing severe and unrelenting doubt. It can cause you to doubt even the most basic things about yourself - even your sexual orientation. A 1998 study published in the "Journal of Sex Research" found that among a group of 171 college students, 84% reported the occurrence of sexual intrusive thoughts (Byers et al, 1998). In order to have doubts about one's sexual identity, a sufferer need not ever have had a homo- or heterosexual experience, or any type of sexual experience at all. I have observed this symptom in young children, adolescents, and adults. Interestingly, Swedo et al in 1989 found that approximately 4% of children with OCD experience obsessions concerned with forbidden, aggressive, or perverse sexual thoughts.

Although doubts about one's own sexual identity might seem pretty straight forward as a symptom, there are actually a number of variations. The most obvious form is where an OCD sufferer experiences the thought that s/he might be of a different sexual orientation than s/he formerly believed. If the sufferer is heterosexual, then the thought may be that s/he is homosexual. If, on the other hand, the sufferer happens to be homosexual, s/he may obsess about the possibility that s/he might really be straight.

Going a step beyond this, some sufferers have obsessions that tell them that they may have acted or will act on their thoughts. A variation on doubt about sexual identity is where the obsessive thought has focused on the idea that the person simply will never be able to figure out what his/her sexual orientation actually is. Patients will sometimes relate their belief that, "I could deal with whatever my sexuality turns out to be, but my mind just won't let me settle on anything." Some people's doubts are further complicated by having such experiences as hearing other people talking or looking in their direction and thinking that these people must be analyzing their behavior or appearance and talking about them, discussing how they must be gay (or straight).

For those with thoughts of being homosexual, part of the distress must surely be social in origin. Let's face it: gay people have always been an oppressed minority within our culture, and to suddenly think of being in this position and to be stigmatized in this way can be frightening. People don't generally obsess about things they find positive or pleasurable. I have sometimes wondered if those who experience the most distress from such thoughts as these do so because they were raised with more strongly homophobic or anti-gay attitudes to begin with, or if it is simply because one's sexuality can be such a basic doubt. I suppose this remains a question for research to answer. The older psychoanalytic therapies often make people with this problem feel much worse by saying that the thoughts represent true inner desires. This has never proven to be so.

Doubting something so basic about yourself can obviously be quite a torturous business. When I first see people for this problem, they are typically engaged in any number of compulsive activities, which may occupy many hours of each day. These can include:

- Looking at attractive men or women, or pictures of them, or reading sexually oriented literature or pornography (hetero- or homosexual) to see if it is sexually exciting.

- Imagining themselves in sexual situations and then observing their own reaction to them.

- Masturbating or having sex repeatedly just for the purpose of checking their own reaction to it. (This may also include visiting prostitutes in more extreme cases).

- Observing themselves for evidence of "looking," talking, walking, dressing, or gesturing like someone who is either gay or straight.

- Compulsively reviewing and analyzing past interactions with other men or women to see if the sufferers have acted like a gay or straight person.

- Checking the reactions or conversations of others to determine whether or not they might have noticed the sufferer acting inappropriately.

- Reading articles on the Internet about how an individual can tell if s/he is gay or straight to see which group s/he might be most similar to.

- Reading stories by people who "came-out" to see if they can find any resemblance to their own experiences.

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• Repeatedly questioning others or seeking reassurance about their sexuality.

Compulsive questioning can frequently take place and usually involves others who may be close to the sufferer. The questions are never-ending and repetitive. Some of the more typical questions sufferers are likely to ask can include those in the following two groupings:

For those who obsess about not knowing what their identity is, the questions are:

• How do I know whether I prefer women or men?

• Maybe I really don't know what I am.

• Maybe I'll never know what I am.

• How does anyone tell what sex s/he really is?

• How will I ever be able to tell what I am for certain?

• What will happen if I make the wrong choice and get trapped in a lifestyle that really isn't for me?

For those who obsess that they are of the opposite sexual orientation, the questions that arise are:

• Do you think I could be gay (or straight)?

• How can I tell if I'm really gay (or straight)?

• At what point in their lives do people know what their orientation is?

• Can you suddenly turn into a homosexual (or heterosexual) even if you have never felt or acted that way?

• Did I just act in a sexual manner toward you?

• Do I look or act gay (or straight)?

• If I get sexual sensations when viewing sexual material of an opposite orientation does it mean I am gay (or straight)?

In terms of the last question above, one of the most difficult situations for this group of sufferers is when they experience a sexual reaction to something they feel would be inappropriate. A typical example would be a heterosexual man who experiences an erection while looking at gay erotica. It is important to note that it is extremely common for people to resort to all sorts of fantasy material concerning unusual or forbidden sexual behaviors that they would never actually engage in, but that they do find stimulating. Under the right circumstances, many things can cause sexual arousal in a person. The fact of the matter is that people react sexually to sexual things. I am not just talking about people with OCD here, but about people in general. I cannot count the number of times that patients have related to me that they have experienced sexual feelings and feelings of stimulation when encountering things they felt were taboo or forbidden. This, of course, then leads them to think that their thoughts must reflect a true inner desire and are a sign that they really are of a different sexual orientation. This reaction is strengthened by the incorrect belief that homosexual cues never stimulate heterosexuals. One further complicating factor in all this is that some obsessive thinkers mistake feelings of anxiety for feelings of sexual arousal. The two are actually physiologically similar in some ways.

Things become even more complicated by a number of cognitive (thinking) errors seen in OCD. It is these errors that lead OC sufferers to react anxiously to their thoughts and then to have to perform compulsions to relieve that anxiety. Cognitive OCD theorists believe that obsessions have their origin in the normal unwanted intrusive thoughts seen in the general population. What separates these everyday intrusions from obsessions seen in OCD are the meanings or appraisals that the OCD sufferers attach to the thoughts. As I like to explain to my patients, the problem is not the thoughts themselves; but instead it is what people make of the thoughts and their attempts to relieve anxiety via compulsions and avoidance.

Some typical cognitive errors made by OC sufferers include:

• I must always have certainty and control in life (intolerance of uncertainty).

• I must be in control of all my thoughts and emotions at all times.

• If I lose control of my thoughts, I must do something to regain that control.

• Thinking the thought means it is important, and it is important because I think about it.

• It is abnormal to have intrusive thoughts; and if I do have them, it means I'm abnormal, crazy, weird, etc.

• Having an intrusive thought and doing what it suggests are the same, morally.

• Thinking about doing harm and not preventing it is just as bad as committing the harmful act (also known as Thought-Action Fusion).

• Having intrusive thoughts means I am likely to act on them.

• I cannot take the risk that my thoughts will come true.

The effect of the questioning behavior on friends and family can be rather negative, drawing a lot of angry responses or ridicule after the thousandth time. One young man I know questioned his girlfriend so often that she eventually broke up with him. This added to his worries since he now wondered if she did so because he wasn't a "real man."

The compulsive activities sufferers perform in response to their ideas, of course, do nothing to settle the issue. Often, the more checking and questioning that is done, the more doubtful the sufferer becomes. Even if s/he feels better for a few minutes as a result of a compulsion, the doubt quickly returns. I like to tell my patients that it is as if that information-gathering portion of their brain is coated with Teflon; the answers just don't stick.

In addition to performing compulsions, one other way in which sufferers cope with the fears caused by the obsessions is through avoidance. By this I mean directly avoiding everyday situations that get the thoughts going. This can involve:

• Avoiding standing close to, touching, or brushing against members of the same sex (or opposite sex if the sufferer is gay).

• Not reading or looking at videos, news reports, books, or articles having anything to do with gay people or other sexual subjects.

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Straight or Gay? An Update

(continued from page 11)

• Never saying the words "gay," "homosexual," (or "straight") or any other related term.

• Trying to not look or act effeminately (if a man) or in a masculine way (if a woman), or vice versa if the sufferer is gay.

• Not dressing in ways that would make one look effeminate (if a man) or masculine (if a woman). Again, vice versa if the sufferer is gay.

• Not talking about sexual identity issues or subjects with others.

• Avoiding associating with anyone who may be gay or who seems to lean in that direction (if the sufferer is heterosexual).

The purpose of compulsions is, of course, to undo, cancel out, or neutralize the anxiety caused by obsessions. They may actually work in the short run, but their benefits are only temporary. Also, it is important to understand that compulsions are paradoxical, i.e., they bring about the opposite of what they are intended to accomplish. They ultimately cause the sufferer to continue to experience anxiety and obsessive thoughts.

I like to tell my patients that: "Compulsions start out as a solution to the problem of having obsessions, but soon become the problem itself."

What compulsions do accomplish is to cause the sufferer to become behaviorally addicted to performing them. Even the little bit of relief they get is enough to get this dependency going. Compulsions only lead to more compulsions, and avoidance only leads to more avoidance. This is really only natural for people to do. It is instinctive to try to escape or avoid that which makes you anxious. Unfortunately, this is of no help in OCD.

Another problem that arises from performing compulsions is that those who keep checking their own reactions to members of the opposite or same sex will inevitably create a paradox for themselves. They become so nervous about what they may see in themselves that they don't feel very excited, and then think that this must mean they have the wrong preference. When they are around members of their own sex, they also become anxious, which leads to further stress and, of course, more doubts about themselves. The flip side of this is that when they look at things having to do with sex of an opposite orientation and then feel aroused in some way, which they then conclude to mean that they liked it, this confirms that they are gay (or straight). This is the mistake I referred to earlier when I stated that people react sexually to sexual things.

People like to ask if there are any new developments in OCD treatments. Aside from a few new medications since the last article, treatment remains essentially the same. The formula of cognitive-behavioral therapy plus medication (in many cases) is still the way to go. The particular form of behavioral therapy shown to be the most effective is known as Exposure and Response Prevention (ERP).

ERP encourages participants to expose themselves to their obsessions (or to situations that will bring on the obsessions), while they prevent themselves from using compulsions to get rid of the resulting anxiety. When doing ERP, the fearful thoughts or situations are gradually increased over a period of several weeks to several months. This results in an effect upon the individual that we call "habituation." That is, when you remain in the presence of what you fear over long periods of time, you will soon see that no harm of any kind results. As you do so in slowly increasing amounts, you develop a tolerance to the presence of the fear, and its effect is greatly lessened. By continually avoiding feared situations and never really encountering them, you keep yourself sensitized.

By facing them, you learn that the avoidance itself is the "real" threat that keeps you trapped. It puts you in the role of a scientist conducting experiments that test your own fearful predictions to see what really happens when you don't avoid what you fear. The result is that you slowly build up your tolerance for whatever is fear-provoking. It begins to take larger and larger doses of frightening thoughts or situations to bring on the same amount of anxiety. When you have finally managed to tolerate the most difficult parts of your OCD, the thoughts and situations can no longer cause you to react with fear. Basically, you can tell yourself, "Okay, so I can think about this, but I don't have to do anything about it." By agreeing to face some short-term anxiety, you can thus achieve long-term relief. It is important to note that the goal of ERP is not the elimination of obsessive thoughts, but to learn to tolerate and accept all thoughts with little or no distress. This reduced distress may, in turn, as a by-product, reduce the frequency of the obsessions. Complete elimination of intrusive thoughts may not be a realistic goal, given the commonality of intrusive thoughts in humans in general.

Using this technique, you work with a therapist to expose yourself to gradually increasing levels of anxiety-provoking situations and thoughts. You learn to tolerate the fearful situations without resorting to questioning, checking, or avoiding. By allowing the anxiety to subside on its own, you slowly build up your tolerance to it, and it begins to take more and more to make you anxious. Eventually, as you work your way up to facing your worst fears, there will be little about the subject that can set you off. You may still get the thoughts here and there, but you will no longer feel that you must react to them, and you will be able to let them pass.

There are many techniques for confronting sexual and other obsessions that we have developed over the years. Some of these techniques include:

• Listening to 2-3 minute audio tapes or tape loops about the feared subject.

• Leaving cell phone voice-mail messages for yourself about the feared subject.

• Writing 2-page compositions about a particular obsession (and then taping them in your own voice).

• Writing feared sentences repetitively.

• Hanging signs in your room or house with feared statements.

• Wearing T-shirts with feared slogans.

• Visiting locations that will stimulate thoughts.

• Being around people who will stimulate thoughts.

• Agreeing with all feared thoughts, and telling yourself they are true and

represent your real desires.

• Reading books on the subject of your thoughts.

• Visiting websites that relate to your thoughts.

The following are some typical exposure therapy homework assignments I have assigned to people over the years:

• Reading books by or about gay persons.

• Watching videos on gay themes or about "gay" characters.

• Visiting gay meetings, shops, browsing in gay bookstores, or visiting areas of town that are predominantly gay.

• Wearing a T-shirt at home with the word "gay" on it.

• Wearing clothes in fit, color, or style that could possibly look effeminate for a man or masculine for a woman.

• Looking at pictures of good-looking people of your own sex and rating them on attractiveness.

• Reading magazines such as *Playboy* if you are a woman or *Playgirl* if you are a man.

• Standing close to members of your own sex.

• Doing a series of writing assignments of a couple of pages each that suggest more and more that you actually are gay or wish to be.

• Making a series of three-minute tapes that, based on the writings, gradually suggest more and more that you are gay, and listening to them several times a day, changing them when they no longer bother you.

Some typical response prevention exercises might include:

• Not checking your reactions to attractive members of your own sex.

• Not imagining yourself in sexual situations with same-sex individuals to check on your own reactions.

• Not behaving sexually with members of the opposite sex just to check your own reactions.

• Resist reviewing previous situations where you were with members of the same or opposite sex, or where things were ambiguous, to see if you did anything questionable.

• Avoid observing yourself to see if you behaved in a way you imagine a homosexual or member of the opposite sex would behave.

Some typical exposure homework for those with doubts about their own sexual identity might include:

• Reading about people who are sexually confused.

• Reading about people who are transgendered.

• Looking at pictures of people who are transgendered or are transvestites

• Telling yourself and listening to tapes telling you that you will never really know what you are.

Some corresponding response prevention exercises to go along with the above would be:

• Not checking your reactions when viewing members of either sex.

• Not acting sexually to simply test your reactions.

• Avoiding reviewing thoughts or situations you have uncertainty about.

Many of the above therapy tasks can sound scary and intimidating. Obviously, you don't do these things all at once. Behavioral change is gradual change. Recovering from OCD is certainly not an easy task. We rarely use the word "easy" at our clinic. It takes persistence and determination, but it can be done. People do it all the time, especially with the proper help and advice. My own advice to those of you reading this would be to get yourself out of the compulsion trap, and get yourself into treatment with qualified people.

Fred Penzel, Ph.D., is a licensed psychologist who has specialized in the treatment of OCD and related disorders since 1982. He is the executive director of Western Suffolk Psychological Services in Huntington, Long Island, New York, a private treatment group specializing in OCD and O-C related problems, and is a member of the OCF Science Advisory Board. Dr. Penzel is the author of "Obsessive-Compulsive Disorders: A Complete Guide To Getting Well And Staying Well," a self-help work covering OCD and other O-C spectrum disorders. Dr. Penzel can be contacted at penzel85@yahoo.com.

Bulletin Board

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FAMILY RESEARCH: THE HOPE FOR TOMORROW

A team of investigators at the Johns Hopkins University School of Medicine has been studying the occurrence of Obsessive Compulsive Disorder (OCD) in families. OCD may have its onset at a young age and it can be benign or extremely disabling. While many treatments have proven effective, we still need to learn more about this disorder. It is critical to learn about the biological basis of OCD to further improve treatments.

At Johns Hopkins School of Medicine, we are now investigating genetic factors which may increase the susceptibility to OCD. Everyday we are coming closer to understanding the complexities of OCD. We are seeking help from families with OCD to help us conduct these studies. With your help, there is hope for better treatments tomorrow.

How You Can Help!

Families having two or more relatives with OCD are invited to participate in the study. Participants will be given a confidential psychiatric interview and if possible we would like to obtain a small sample of blood. The interview will be conducted at a place and time convenient for you. Confidentiality of all information is assured. Families may be referred by a clinician or may contact us. Each participant's help is vital and it brings us one step closer to getting crucial answers.

To learn more about the study please call Gerald Nestadt, M.D., M.P.H., at (410) 614-4941 and a Research Associate will contact you. Or write: The Johns Hopkins University School of Medicine, Department of Psychiatry, 600 N. Wolfe Street, Meyer 4-181, Baltimore, MD 21287. Email: jacks@welchlink.welch.jhu.edu.

DRUG STUDY FOR HAIR PULLERS

Do you pull your hair? Is it causing problems? Does it feel out of control? We are currently seeking volunteers for a drug study for hair pulling. Participation is confidential and requires visits to our Minneapolis, MN site. Please email or call

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Bulletin Board

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if you would like more information.

Brian Odlaug, Reseach Coordinator, Department of Psychiatry, University of Minnesota, (612) 627-4363 (confidential line), email: odla0019@umn.edu.
Jon Grant, M.D., Department of Psychiatry, University of Minnesota, (612) 273-9736 (confidential line), email: grant045@umn.edu.

Treatment for Obsessive Compulsive Disorder

The Anxiety Disorders Center at Hartford Hospital/Institute of Living is conducting research on new ways to treat obsessive compulsive disorder. The study is open to adults ages 18-65 who have OCD. Participants in the ongoing studies will receive free cognitive-behavioral therapy, one of the most effective treatments for OCD. People who are not currently taking medications for OCD may be eligible for a study on cognitive-behavioral therapy in combination with an experimental medication. People who are currently on medications for OCD may be eligible to participate in a study of CBT using "stepped care" – a model of treatment which begins with less intensive therapy and moves to more intensive therapy for those who have not yet reached maximum benefit.

For more information, please call Sarah Carlson at (860) 545-7707 or visit us on the web: www.instituteofliving.org/ADC/index.htm.

OCD Research at the U.S.-Mexico Border

The College of Health Sciences at the University of Texas at El Paso is conducting research about OCD in relation to culture and ethnicity.

Are you:

- Suffering from OCD (diagnosed or not)
- Of Mexican or Mexican-American background
- Over age 18
- Living in the El Paso, TX - Ciudad Juarez, Chih. (Mexico) border area

We have a one-time confidential interview that lasts about 40-60 minutes. We will ask you about quality of life, symptoms, availability of treatment, culture, etc. We provide a $25 gift certificate in compensation for your time.

Contact Oriana Perez at (915)747-8317 or at operez@utep.edu, or Dr. Tom Olson at (915) 747-7246 or at tolson@utep.edu to schedule an interview.

OCD Treatment Study for Children and Adolescents

If your child or teen (ages 7-17) is suffering from Obsessive-Compulsive Disorder, he or she may be able to participate in a research study at the National Institute of Mental Health in Bethesda, MD. We are investigating the medication riluzole which has been reported to benefit adults with OCD or depression. We expect that riluzole will decrease obsessive compulsive symptoms in children and adolescents.

Children with a primary diagnosis of OCD, who reside within commuting distance of Bethesda, MD, may be eligible. Children will receive a one-day comprehensive psychiatric and medical evaluation, and follow-up visits every two weeks for 3 months, and at 4, 6, and 12 months. There is no charge to participate; travel assistance is provided.

Dr. Paul Grant, MD, a child and adolescent psychiatrist, is the Principal Investigator. For further information please contact Lorraine Lougee, LCSW-C at 301-435-6652 or Matthew Hirschtritt at 301-496-5323, or email OCDNIMH@intra.nimh.nih.gov.
This study is run by the National Institute of Mental Health, National Institutes of Health, Department of Health and Human Services.

OCD and Hoarding Study

The Institute of Living in Hartford, CT and The Boston University School of Social Work are conducting research to understand the features of obsessive compulsive disorder and compulsive hoarding. The study compares people with hoarding problems to those who have obsessive-compulsive disorder (OCD). It is not necessary for participants to have hoarding problems or clutter to participate. The researchers hope to learn more about why hoarding and obsessive compulsive symptoms develop, how these problems are related to other psychiatric disorders and how best to assess these problems. This information may be helpful for identifying effective treatments in the future.

Researchers are looking for people age 18 or older who have (1) problems with excessive clutter or (2) obsessive-compulsive disorder and, (3) live within forty minutes of the greater Hartford or Boston areas. The study consists of a 4-hour diagnostic interview about anxiety and mood symptoms followed by a 4-hour interview about clutter and acquiring. These interviews take place at the clinics.

Additionally, the study will include a 1-hour visit to the participant's home where the participant will take part in an experimental task about removing clutter and another task about acquiring new items. Participants will also have a chance to take part in a discarding and acquisition task. Participants will be paid $20/hr for their time and can make up to $180.

If you are interested in participating and have any questions, please contact Jessica Rasmussen, B.A., at Boston University at (617) 358-4213 or (617) 353-9610 or Kristin Fitch, B.A., at The Institute of Living in Hartford, CT at (860) 545-7574.

It's Time to Start Thinking About Attending the 14th Annual OCF Conference at The Woodlands Waterway Marriott Hotel & Convention Center The Woodlands, Texas July 20-22, 2007

Expenses for Mental Illness

(continued from page 1)

Timothy's Law was passed because of the tireless efforts of Timothy's parents, Tom and Donna O'Clair. They crusaded for this bill since Timothy's death in 2001. With the passage of this bill, New York now joins some 39 other states that have passed similar bills which eliminate some of the discrimination that individuals with mental illness face.

If your state has not passed parity legislation yet, call your state representative and tell him/her that you support parity in health insurance.

Compliance with Solicitation Regulations

The Obsessive Compulsive Foundation, Inc. ("OCF") is a Connecticut not-for-profit corporation. Its mission is to educate the public and professional communities about Obsessive Compulsive Disorder ("OCD") and related disorders; to educate and train mental health professionals in the latest treatments for OCD and related disorders; to provide assistance to individuals with OCD and related disorders and their family and friends; and to support research into the causes and effective treatment of OCD and related disorders. The OCF's principal place of business is 676 State Street, New Haven, Connecticut 06511-6508. The information enclosed herein describes one or more of the OCF's activities. Your gift is tax deductible as a charitable contribution. Contributions received by OCF do not inure to the benefit of its officers, directors or any specific individual.

A copy of OCF's most recent financial report is available upon request and may be obtained at no cost by writing to OCF at P.O. Box 9573, New Haven, Connecticut 06535-0573 or by contacting its Executive Director at (203) 401-2074. If you are a resident of one of the following states, you may obtain information directly as follows: **Florida**: A COPY OF THE OFFICIAL REGISTRATION AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE FLORIDA DIVISION OF CONSUMER SERVICES BY CALLING TOLL FREE WITHIN THE STATE (800) 435-7352, OR (850) 488-2221 IF CALLING FROM OUTSIDE FLORIDA. OCF'S REGISTRATION NUMBER IN FLORIDA IS CH8507. **Maryland**: A copy of the documents and information submitted by the OCF pursuant to the Maryland Charitable Solicitations Act are available for the cost of copies and postage from the Secretary of State, State House, Annapolis, MD 21401, Telephone (401) 974-5534. OCF's registration number in Maryland is 5015. **Mississippi**: The official registration and financial information of OCF may be obtained from the Mississippi Secretary of State's office by calling (888) 236-6167. OCF's registration number in Mississippi is C1143. **New Jersey**: INFORMATION FILED WITH THE ATTORNEY GENERAL CONCERNING THIS CHARITABLE SOLICITATION MAY BE OBTAINED FROM THE ATTORNEY GENERAL OF THE STATE OF NEW JERSEY BY CALLING (973) 504-6215. OCF'S REGISTRATION NUMBER IN NEW JERSEY IS CH1461800. **New York: A copy of the most recent annual report filed by OCF with the New York Secretary of State may be obtained by writing to Charities Bureau, 120 Broadway, New York, NY 10271, Telephone (518) 486-9797. OCF's registration number in New York is 66211. North Carolina: A COPY OF THE LICENSE TO SOLICIT CHARITABLE CONTRIBUTIONS AS A CHARITABLE ORGANIZATION OR SPONSOR AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE DEPARTMENT OF HUMAN RESOURCES, SOLICITATION LICENSING BRANCH, BY CALLING (919) 733-4510. OCF'S REGISTRATION NUMBER IN NORTH CAROLINA IS SL002059. Pennsylvania**: A copy of the official registration and financial information may be obtained from the Pennsylvania Department of State by calling toll free, within Pennsylvania, (800) 732-0999. OCF's registration number in Pennsylvania is 15687. **Virginia**: A copy of the OCF's most recent financial statement is available upon request from the State Division of Consumer Affairs in the Department of Agriculture and Consumer Services. **Washington**: Additional financial disclosure information may be obtained by contacting the Secretary of State toll free, within Washington, at (800) 332-GIVE. OCF's registration number in Washington is 6363. **West Virginia**: West Virginia residents may obtain a summary of the registration and financial documents from the Secretary of State, State Capitol, Charleston, West Virginia 25305.

REGISTRATION WITH A STATE AGENCY DOES NOT CONSITUTE OR IMPLY ENDORSEMENT, APPROVAL OR RECOMMENDATION BY THAT STATE.

THE OCF DOES NOT HAVE A PROFESSIONAL SOLICITOR. ONE HUNDRED PERCENT OF EVERY CONTRIBUTION IS RECEIVED BY THE OCF. DONATIONS WILL BE USED TO UNDERWRITE THE OCF'S PROGRAMS, ACTIVITIES AND OPERATIONS AS WELL AS FOR RESEARCH.

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Telephone: (203) 401-2070 Fax: (203) 401-2076 E-mail: info@ocfoundation.org

ADDITIONAL DONATIONS TO SUPPORT OCF'S WORK ARE GRATEFULLY ACCEPTED.

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