

YALE RESEARCHERS LOOKING AT OTHER PHARMACOLOGICAL TREATMENTS FOR OCD

By Vlad Coric, M.D.
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Unfortunately, treatment with serotonin-reuptake inhibitor (SRI) medications or cognitive-behavioral therapy does not result in a full remission of OCD symptoms for all patients. In fact, even those who do benefit from medications or therapy can have persistent symptoms that remain quite debilitating. Research centers like the Yale OCD Research Clinic have been focusing their efforts on identifying new pharmacological approaches for patients whose OCD symptoms do not improve enough from standard therapies.

Investigators at the Yale OCD Research Clinic, led by Drs. Vlad Coric and Christopher Pittenger, have been focused on the use of medications that work on the neurotransmitter glutamate. Glutamate is an excitatory neurotransmitter and abundant in the central nervous system. There is a growing body of literature that

suggests glutamate is dysregulated in OCD as well as in other psychiatric disorders.

As discussed in previous OCF Newsletters, preliminary studies examining the use of riluzole, a glutamate modulating agent, as an augmentation medication to SRI medications suggest that this drug may be beneficial to some patients. Riluzole is FDA approved for the treatment of amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's disease) and is available by prescription. In a study published in 2005, researchers at the Yale OCD Research Clinic described the first 13 patients treated with riluzole augmentation. All of these patients still had severe OCD symptoms despite standard treatments, and 7 out of the 13 patients improved after 12 weeks of riluzole treatment.

While open-label results like this need to be interpreted cautiously as there was no comparison control group receiving placebo, the 2005 pilot study suggested that glutamate modulating

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My Last Adventure as ED: Or, Why We Need More Effective Treatments for OCD

By Patti Perkins

I want to tell you the story of my "last adventure as executive director" of the OC Foundation. It's a cautionary tale. And there may be a quiz at the end. The day in question was January 31, a Thursday. The New Haven office was closing that day. Daisy and Jeannette were going to wait for the Pitney Bowes men to come and take away the mailing machinery. Once that was done, the office would be completely empty. No phones, no computers, no electric coffee pots. It's an issue I had. But everything involved with the coffee pot turned out alright. Because, although she rolled her eyes back and gave me the "no reassurance-seeking look," Jeannette did assure me that she would unplug the broken coffee maker and throw it out so that I would not have to drive back down to see that it was unplugged. Unplugging things that heat up is one of those compulsions I should be working on. But I'm getting ahead of myself.

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OCD and Tourette Syndrome: Re-examining the Relationship

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At the outset of this article I would like to thank the hundreds of kids whom I have seen professionally in my more than twenty-five years of clinical practice. They were as much my teachers as my patients in that they opened my eyes to numerous insights, some of which are outlined here. Many were indulgent enough to describe their experience with OCD and related problems in such exquisite detail that they shaped my thinking – and re-thinking – of what I thought I knew about OCD, Tourette Syndrome (TS), and the multitude of clinical features that often presented within the same young packages. Some just had OCD in its familiar forms and others, just tics.

But many had a hodge-podge of clinical features – OCD and TS and ADHD (attention deficit hyperactivity disorder) and LDs (learning disorders) and ODD (oppositional defiant disorder) and ... you name it. I had innumerable opportunities to learn about their firsthand experiences so near to the genesis of their own disorders. As a result, a picture began to emerge that was consistent with their descriptions but often at odds with orthodox views. Here I will briefly outline several perspectives that derive from a re-examination of the relationship between OCD and TS based on that picture.

OCD vs. Tics and Tourette Syndrome (T/TS)

It is useful to start by examining some of the commonly accepted views of OCD and tic disorders, with more attention to tic disorders,

since readers of this article are likely to be more familiar with OCD.

OCD is characterized by obsessions – frequent, unwanted, upsetting and maladaptive thoughts or images that a person can't get out of his/her consciousness. These are often associated with ritualized overt or covert

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Message From the President

Dear Friends of the Foundation,
We've moved!

On January 31, 2008 the Obsessive Compulsive Foundation closed the national office in New Haven, Connecticut and moved its new office to Water Street in Boston, Massachusetts.



Many of you have moved at least once in your lives and you know the

Herculean task that is involved. This relocation would not have happened if it were not for the incredible support that was provided by several OCF board members. In particular, I would like to thank Diane Davey and Michael Stack, the newest addition to the OCF Board of Directors, for assisting me in this process.

Michael Stack joined the board in June 2007 upon the encouragement of Dr. Jenike and Diane Davey. Through his wife Denise, who is a behavioral therapist, Michael learned about the struggles of those diagnosed with OCD and how the OCF plays a role in trying to alleviate them. Michael, who has been working for thirteen years at SRB Corporation, managing investment portfolios for institutional clients and helping to establish the firm, felt that he was at a point in his career where he had the time and the resources to devote to philanthropy.

With Michael Stack's undergraduate degree in Finance from Stonehill College, an MBA from Boston University, a Chartered Financial Analyst (CFA) designation and his work in the financial sector, he immediately proved to be an asset to the Foundation. In just a short time, Michael has made his mark on the OCF Board of Directors, volunteering for the OCF's Finance Committee, the Audit Committee and the Boston Relocation Committee. Michael's analyses were invaluable as we evaluated office space, hired a search firm for the new Boston Staff,



interviewed candidates for the new Executive Director Position, reviewed retirement plans and health insurance policies, and organized the move to Boston.

At the same time, we have been working with the Nonprofit Professionals Advisory Group (NPAG), an executive search firm, to staff the Boston office. The Relocation Boston Committee interviewed candidates recommended by the search firm for the OCF's new Executive Director. And on Friday, January 4, 2008, the OCF Board welcomed its new Executive Director, Michael Brogioli.

Michael Brogioli previously worked for Special Olympics International in Washington, DC, as Vice President for Policy and Government Relations. While he served in that capacity, Michael led an effort to gain over ten million dollars in federal funding annually to benefit its health and education initiatives. He also secured foundation and corporate grants to underwrite a major *Global Policy Summit on the Wellbeing of People with Intellectual Disabilities*. Before his stint at the Special Olympics, he was the Executive Director of the Autism Coalition for Research and Education where he oversaw a two million dollar annual budget, networked with dozens of autism organizations, raised funds, dispensed \$ 500,000 in grants annually, interfaced with scientific and medical experts in the field, and managed staff and volunteers to advance autism programs and to raise public awareness of the disorder.

Michael Brogioli comes to the Foundation with energy and a commitment to develop new projects while at the same time preserving the support services for constituents who need assistance. In January before the New Haven office closed, Michael spent significant time there learning about the Foundation and how it serves its constituents.

As we embark on this new stage of the OCF, we hope that you will welcome Michael Stack, our newest OCF Board member, and Michael Brogioli, our new Executive Director. The Boston office officially opened on February 11, 2008. During the next few months, we will be working closely with NPAG to build our staff. We know that transitions always present chal-

lenges but we will do our best to help you as soon as we can if you call (617) 973-5801, or email us at info@ocfoundation.org.



Many of you have asked who will be in the Boston office to answer the phones, to listen to callers' stories and to guide those with OCD through the process of finding

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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.

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, products or treatments mentioned with a licensed treatment provider.

The Role of Fear Conditioning in OCD

By Paul R. Munford, Ph.D.

One of the earliest, and better, psychological explanations for the acquisition and elimination of OCD symptoms is Mower's two-stage theory (Mower, O. H. 1947). In the first stage, classical conditioning occurs. The best-known example of classical conditioning is Pavlov's experiment that conditioned a dog to salivate by ringing a bell. This was achieved by ringing a bell (a neutral stimulus) and presenting the animal with meat powder, a substance that naturally elicits salivation (an unconditioned stimulus). After a number of such pairings of the meat powder and bell, the dog salivated in response to the bell alone. The bell had been transformed from a neutral stimulus to a conditioned stimulus for salivation. Classical conditioning works with people as well. For example, if a person has an unexpected frightening experience, for instance being robbed at gunpoint by a short man (unconditioned stimulus), he or she can become fearful of other short men (conditioned stimuli) even though the person knows most short men are harmless. Thus, short men who were previously neutral stimuli, having been paired with the trauma of robbery, are transformed into conditioned fear stimuli. This is classical conditioning of fear.

Mary's* case is a good example of the first stage of Mower's theory on the acquisition of obsessions. She recalled that as a seven-year-old child she developed a fear of contracting cancer from an aunt with terminal carcinoma who came to live with her family. The aunt had a favorite chair she always sat in that Mary associated with her fear of cancer, so that eventually, simply the site of the chair provoked dread in the child. Thus, by means of classical conditioning, the chair became a conditioned stimulus for fear and anxiety.

However, in OCD the conditioning does not stop with just one association of a neutral and feared stimulus. It continues by means of higher order conditioning to include more and more situations, objects, and events. Continuing with Mary's example — other people sat in the aunt's chair; and by means of higher order conditioning, they too became conditioned stimuli for fear. Furthermore, the aunt sat on other furniture and touched other objects in the house. So a kind of fear conditioning contagion took place that transformed many non-fearful situations, events, circumstances, people, etc., into conditioned stimuli for fear. By the time

Mary started treatment when she was 51 years old, she felt contaminated whenever she ventured from her apartment into the outside world that she now considered teaming with triggers for cancer. So to prevent cancer, immediately upon coming home, just inside the doorway, she practiced the compulsion of completely undressing, depositing her clothes in a special container, and then sponging down her entire body with alcohol to "decontaminate herself"; then she felt "comfy." If she didn't wash, she experienced intense anxiety until she did. Her bathing is an example of the second stage of Mower's two-stage theory.

In Mower's second stage, operant conditioning occurs. This type of conditioning happens when behaviors become more frequent if followed by satisfying consequences but less frequent if followed by adverse consequences. Everyday examples include awarding bonuses to employees for increased production, or docking employees for missing deadlines. In OCD, people, motivated to relieve fear, learn by trial and error to perform certain compulsive behaviors or mental activities that result in the satisfying consequences of diminished anxiety — but only until the next cycle of obsession and compulsions. Nevertheless the immediate reward from anxiety relief is positive enough to perpetuate ongoing compulsions in response to continuing obsessions. Once the rituals are established, they become entrenched as the only means of coping with fear and thereby prevent habituation. That is, if the person sits with the fear, it naturally burns itself out as the physiological resources for "fight or flight" are depleted, and the fear is extinguished.

Fortunately, both forms of conditioning can be eliminated through the process of extinction. This requires exposure to conditioned fear triggers (e.g., things that stimulate the fear of contracting cancer) in the absence of the unconditioned stimulus (e.g., actually contracting cancer), which neutralizes the conditioned fear triggers, rendering them incapable of provoking further distress. For OCD, this means repeatedly exposing the person to the conditioned fear triggers only. The unconditioned fear is always absent because the dangers posed by obsessions are always unreal or highly unlikely (e.g., contracting cancer from exposure to the outside world). As a result, the fear triggering content of the obsessions is extinguished.

Having been unaware of the need to experi-

ence the fear instead of avoiding or blocking it, patients have distracted themselves by using avoidance and rituals and therefore have not experienced habituation, the natural elimination of anxiety, from exposure to obsessions not followed by rituals. In other words, instead of avoiding contact with fear, it must be faced. With the elimination of the conditioned fear, the obsessions fade away; and with no obsessions there is no need for further compulsions.

Mower's theoretical formulation was the basis for the first successful psychological treatment of OCD by Victor Meyer in 1966 (Meyer, 1966). His treatment techniques were further developed and promulgated by Edna Foa and others, hence redefining OCD as highly treatable by the technique now known as exposure and ritual prevention (ERP).

Returning to our case example, Mary was treated with exposure and ritual prevention exercises by systematically practicing exposure to the conditioned fear triggers outside her apartment and then refraining from washing rituals until the anxiety triggered by the exposures had dissipated. After repeated practice her obsessions lost their power to provoke fear, and she washed normally. Many people wonder why this elimination of fear has not yet occurred in view of the fact that they have been exposed to it for months or even years. The answer is that they escape from it by ritualizing and avoiding, thereby preventing sufficient exposure. But once the obsessions receive extended and repeated exposure to the light of day — as is the case with vampires as well — they fade away and can even disappear.

Scientific studies show that these techniques significantly reduce symptoms in 75 percent of those treated (Foa & Kozak, 1996). Furthermore, a study my UCLA colleagues and I conducted demonstrated that exposure and response prevention is associated with changes in the brain chemistry of OCD clients that are correlated with reductions in their symptoms (Baxter et al. 1992).

Paul R. Munford, Ph.D., is a clinical psychologist and director of the Cognitive Behaviour Therapy Center for OCD and Anxiety in San Rafael, CA. He is also author of "Overcoming Compulsive Checking: Free Your Mind from OCD" and "Compulsive Washing: Free Your Mind from OCD."**

** These books are available through the OCF bookstore.

*The patient's name and situation have been changed to protect her privacy.

PEOPLE WITH BDD OFTEN HAVE A DIST

This article is part of our "How I Treat" series. There is also another "How I Treat" on page 16. This issue we are featuring BDD.

An Interview with Katharine Phillips, M.D.

NEWSLETTER: In the last few years there has been a lot of interest in Body Dysmorphic Disorder (BDD). Can you describe what it is?

DR. PHILLIPS: People with body dysmorphic disorder, or BDD, are preoccupied with non-existent or slight defects in their physical appearance. People with BDD think something is very wrong with how they look, whereas they look normal to other people. The appearance preoccupations must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. In addition, the preoccupation isn't better accounted for by another mental disorder such as anorexia nervosa.

NEWSLETTER: How would you diagnose BDD?

DR. PHILLIPS: BDD can be diagnosed by asking straightforward questions that mirror the description I just gave. These questions ask about preoccupation with one's appearance as well as resulting distress and interference in various areas of functioning. If the person's concerns focus on his/her weight, or s/he worry that certain body areas (such as their stomach) are too fat, the clinician needs to ascertain that anorexia nervosa or bulimia nervosa aren't more accurate diagnoses. However, people can have both BDD and an eating disorder.

There are a few helpful things to keep in mind when asking about BDD symptoms. First, it's better not to use the word "imagined" to refer to the perceived physical flaws, because most people with BDD don't realize that they have a distorted view of their appearance. Second, it's better not to start out by asking the person if s/he thinks s/he is "deformed" or "disfigured." Words like these can be too strong for some people with BDD to endorse. It's better to simply ask if they're worried about their appearance and then ask what words they'd use to describe the disliked body areas. I'd also suggest not asking whether they think something is wrong with their body, as some people interpret this question to refer to their physical health or how their body (for example, their digestive system) is working. With these kinds of questions, you could miss the diagnosis of BDD.

BDD often goes undiagnosed because many people with this disorder are very embarrassed by their appearance concerns and are reluctant to bring them up. They're often worried that if they reveal their concerns to you, you'll think they're vain, silly, or superficial. But BDD isn't vanity – it's a serious mental illness. People with

BDD really suffer. Anything you can do to help the person feel comfortable will make it easier for him/her to reveal and discuss their BDD symptoms.

NEWSLETTER: What are the symptoms of BDD?

DR. PHILLIPS: People with BDD are preoccupied with the idea that some aspect of their appearance is ugly, unattractive, deformed, flawed, or defective in some way. They often focus on perceived flaws of their face or head, but they can worry about any body area. Skin concerns (for example, perceived acne, scars, lines, or pale skin), hair concerns (for example, perceived thinning or excessive body or facial hair), and nose concerns (for example, nose size or shape) are common. Most people are preoccupied with a number of different body areas.

BDD preoccupations are distressing, time consuming (occurring for an average of 3-8 hours a day), and usually difficult to resist or control. Most people think that their view of their appearance is definitely or probably accurate. In other words, they don't realize that their view of how they look is distorted and inaccurate. This is an important difference from OCD, where people usually realize that the consequence they fear will happen (for example, that they'll get sick because they touched a faucet) probably isn't really true. In addition, most people with BDD believe that other people take special notice of them in a negative way — for example, stare at them, talk about them, or mock them — because of how they look.

Nearly all people with BDD perform compulsive behaviors that focus on examining, improving, hiding, or getting reassurance about the perceived appearance flaws. Like OCD compulsions, these behaviors are time consuming, usually occurring for hours a day. They're also typically difficult to resist or control. Some of the most common ones are mirror checking, comparing their appearance with that of other people, compulsive grooming (for example, excessive hair styling, shaving, or face washing), skin picking, reassurance seeking, clothes changing, and tanning (to darken "pale" skin or try to improve facial blemishes or scarring). Most people also try to hide the flaws they perceive — for example, by covering their face with their hair, their eyes with sunglasses, their hair with a hat, or their skin with heavy makeup. I provide a lot more information about BDD symptoms in my book, *The Broken Mirror: Understanding and Treating Body Dysmorphic Disorder*,* published by Oxford University Press.

NEWSLETTER: What is the difference between BDD and a concern with one's appearance?

DR. PHILLIPS: BDD echoes normal appearance concerns, but it's more severe and problematic. In this way, it's similar to anorexia nervosa, which echoes the wish many women have to be thin, but is clearly more severe than normal weight concerns and normal dieting. People with BDD don't just have some passing thoughts about their appearance — they overly focus on their appearance and worry about it a lot. In addition, the appearance concerns cause significant problems in functioning — for example, socially, or with work, school or other activities — or significant emotional distress, usually both. Level of functioning varies from person to person, but on average is very poor.

It's easy to confuse BDD with vanity, but BDD is an unusually distressing disorder. In fact, most people with BDD have had thoughts that life isn't worth living or wished they were dead, and a quarter or more have attempted suicide. Much more research is needed on actual suicide, as the research data we have so far are limited; but it appears that the rate of completed suicide is markedly high.

NEWSLETTER: Does everyone who wants to look his/her best have BDD?

DR. PHILLIPS: No, definitely not. Taking care of basic grooming and wanting to look good is normal.

NEWSLETTER: Is BDD an OCD spectrum disorder? What does that mean?

DR. PHILLIPS: BDD is widely considered to be an OCD spectrum disorder — that is, a disorder with similarities to OCD and presumably some shared causes. BDD and OCD have many similarities, the most obvious being that people with BDD are very obsessed and perform compulsive behaviors, like people with OCD. BDD and OCD often co-occur, and BDD has been found to be more common in relatives of people with OCD than in relatives of people without OCD (healthy controls), suggesting that they may be related conditions. There are additional indications that they are related disorders, but BDD and OCD also have some differences, which suggests that they aren't identical disorders.

NEWSLETTER: Who is affected by BDD? Do more women than men have BDD?

DR. PHILLIPS: BDD affects people of all ages, from children to the elderly. As best we know, BDD appears to affect somewhat more women than men, or men and women about equally.

NEWSLETTER: Is there an age range when people start exhibiting the symptoms of BDD?

ORTED VIEW OF HOW THEY REALLY LOOK

DR. PHILLIPS: BDD most often begins during early adolescence, although it can begin as early as age 4 or 5 and as late as the 40s.

NEWSLETTER: Does BDD occur comorbidly with OCD and/or other OCD spectrum disorders?

DR. PHILLIPS: Yes. Studies focusing on BDD have found that about one third of people with BDD also have OCD. So when a clinician sees a person with BDD, it's important to ask whether s/he also has OCD, as well as depression, social phobia, and alcohol or drug abuse or dependence, which are also common in people with BDD. Tourette Syndrome and trichotillomania appear far less common in people with BDD, each occurring in about 3% of people with BDD. Studies focusing on OCD have found that anywhere from about 3% to nearly 40% of people with OCD also have BDD, depending on the study.

NEWSLETTER: What is the generally accepted treatment for BDD now?

DR. PHILLIPS: The two types of accepted treatment are the serotonin-reuptake inhibitors (SRIs) and cognitive-behavioral therapy.

NEWSLETTER: What medications are used to treat BDD? How effective are these medications?

DR. PHILLIPS: Serotonin-reuptake inhibitors (SRIs, or SSRIs) are currently considered the medication of choice for BDD. A number of studies indicate that these medications significantly improve BDD symptoms in a majority of people. When people improve with an SRI, they usually obsess less about their appearance, are less distressed over how they look, have better control over their compulsive behaviors, and function better in their daily lives. Sometimes they think they actually look better. We've also found that depressive symptoms and suicidal thinking often improve. SRIs are also often effective for people who are completely convinced that they look ugly or abnormal.

Improvement with an SRI usually develops gradually, and SRI treatment may require up to 12-14 weeks to work. An important point is that relatively high SRI doses — higher than those typically used for depression — appear to often be needed to successfully treat BDD. I provide much more detailed information about medication treatment of BDD in my book.

NEWSLETTER: Is cognitive-behavior therapy used to treat BDD?

DR. PHILLIPS: Yes, a number of studies indicate that cognitive-behavioral therapy that specifically targets BDD symptoms is often helpful for BDD. CBT is currently considered the first-line therapy for BDD.

NEWSLETTER: Is exposure and response prevention therapy effective for BDD?

DR. PHILLIPS: Exposure and response prevention are part of CBT for BDD. Exposure often involves exposure to other people or social situations, without performing one's rituals, such as fixing one's makeup or mirror checking during the exposure. Response prevention involves cutting back on or stopping compulsive behaviors such as excessive grooming, mirror checking, comparing, and skin picking. We recommend that exposure be combined with behavioral experiments, so that during the exposures the person gathers evidence to determine whether his/her beliefs about his/her appearance are true or not. Most BDD studies have combined exposure and response prevention with cognitive therapy. Cognitive therapy helps the person develop more accurate and helpful beliefs about his/her appearance. Some additional elements of CBT that may be helpful are mirror retraining, habit reversal for compulsive skin picking or hair removal, and motivational interviewing for people who are reluctant to try or stick with CBT.

NEWSLETTER: What kinds of exposures would you suggest a therapist try with the BDD sufferer?

DR. PHILLIPS: We suggest using a hierarchy that enables the person to gradually face feared and avoided situations. Usually these are situations that involve being around other people — for example, going to the store, to a social gathering, or to school or work. In this sense, exposure for BDD is like exposure for social phobia. The goal of exposure is not to avoid any situations because of BDD and to feel more comfortable in these situations. We also encourage people to use cognitive strategies — specifically, cognitive-restructuring — before, during, and after the exposure. Dr. Sabine Wilhelm's book, *Feeling Good About the Way You Look*,* offers a lot more information about CBT, including exposure, for BDD.

NEWSLETTER: Are there any other effective treatments for BDD? What are they?

DR. PHILLIPS: At the moment, there isn't any scientific evidence that other treatments are effective. But we need much more treatment research.

NEWSLETTER: Are there any treatments that you know therapists are using that are not effective?

DR. PHILLIPS: As best we know, supportive or insight-oriented therapy by themselves probably aren't effective for BDD, although they may be helpful for other problems that someone with

BDD may have. Also, cosmetic treatment, such as surgery, dermatologic treatment, or dental treatment, isn't recommended for BDD. As best we know, these treatments — which most people with BDD get — aren't effective for BDD and can even make BDD worse.

NEWSLETTER: If someone has BDD with whom should s/he consult? A psychiatrist or a cognitive-behavioral therapist or both?

DR. PHILLIPS: Either or both. The most important thing is to look for a clinician who is knowledgeable about BDD and currently recommended treatments for BDD. However, for people who are very depressed or suicidal, I'd always recommend an SRI — some people with BDD are highly suicidal and need medication. It's also important to consider whether the person has other problems that may also need to be treated. For example, a problem with drugs or alcohol may need specific treatment for that problem.

NEWSLETTER: With the treatments you've described should someone suffering from BDD get significantly better?

DR. PHILLIPS: Yes, most people do get better! But it's important that the medication be properly prescribed — for example, that an SRI is used and that the dose is high enough. If one SRI doesn't work, another should be tried, because sometimes it will work. Sometimes it's helpful to add other medications to an SRI. It's also important to find a therapist who's trained in CBT and familiar with BDD. Sometimes persistence with treatment is needed, but most people will get better with the right treatment, so never give up hope!

But we do need much more treatment research on BDD. Dr. Sabine Wilhelm, at Massachusetts General Hospital and Harvard Medical School in Boston, Dr. Eric Hollander in New York City and Mount Sinai Medical School, and I are currently conducting treatment studies for children, adolescents, and adults with BDD which offer free study treatment for people who qualify. We hope that by doing this research, even more people will be able to overcome this often-severe disorder.

Katharine Phillips, M.D., is Professor of Psychiatry and Human Behavior at The Warren Alpert Medical School of Brown University and Director of the Body Dysmorphic Disorder and Body Image Program at Butler Hospital in Providence, RI (401-455-6466). You can visit her website at www.BodyImageProgram.com or at www.butler.org/body.cfm?id=123. Dr. Wilhelm can be contacted at 617-643-4779, and you can visit her website at www.massgeneral.org/bdd/. Dr. Hollander can be contacted at 212-241-3116.

*These books are available through the OCF Bookstore.

Research Digest

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

Correlates of occupational disability in a clinical sample of obsessive-compulsive disorder

Comprehensive Psychiatry, 49:43-50, 2008, M.C. Mancebo, B. Greenberg, J.E. Grant et al.

This study examined characteristics of individuals with OCD who were unable to work (occupationally disabled). Information came from 238 patient interviews from the Brown Longitudinal OCD Study, a follow-up study on the course of OCD. A substantial number of individuals were unable to work: 38% (90 individuals) reported being unable to work for psychiatric reasons. One important finding was that 82% of these 90 individuals had held paid employment positions in the past and one-third had been working as executives, professionals, or administrators. Researchers compared individuals with occupational disability to those without it. Findings included OCD with occupational disability was associated with greater functional impairment in completing household duties, social functioning, and quality of life. Few differences in treatments received were found among individuals with and without occupational disability. Cognitive-behavior therapy was underutilized and reasons for this were unclear. The severity of OCD was the most powerful predictor of occupational disability, followed by severity of co-occurring depression and presence of substance abuse.

Course of obsessive-compulsive disorder during early postpartum period: a prospective analysis of 16 cases

Comprehensive Psychiatry, 48:558-561, 2007, F. Uguz, K. Gezginc, I.E. Zeytinci et al.

Previous research has reported the onset or worsening of OCD after childbirth. Most of these studies have been retrospective (looking back). This is a small study that was prospective, assessing OCD symptoms at the end of 38 week pregnancies and again at 6 weeks postpartum in 16 women. The Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) was used to measure the severity of symptoms. Compared to the severity of OCD symptoms at the 38th week of pregnancy, symptom severity increased in 5 of the women and most interestingly, symptom severity decreased in the other 11 women. This study suggests that the severity of OCD symptoms is likely to diminish in a majority of new mothers. The study is small and the postpartum follow-up period is relatively short, only 6 weeks, so the course of OCD may change in following weeks.

Changes in quality of life following cognitive-behavioral therapy for obsessive-compulsive disorder

Behaviour Research and Therapy, 45:3060-3068, 2007, G.J. Diefenbach, J.S. Abramowitz, M.M. Norberg et al.

Effectiveness of cognitive-behavioral therapy (CBT) in reducing OCD symptoms is well documented. This study explored CBT's effects on quality of life, with the hypothesis that improvements in OCD symptoms would contribute to improvements in overall life functioning. Family, social, and work functioning were evaluated in 70 adult patients with OCD, before and after CBT. Significant and substantial improvements in family and social functioning corresponded to improvements in OCD symptom severity, even after controlling for improvements in depressive symptoms. Improvement in work functioning did not correlate with improvement in OCD, likely because a significant number of patients (27%) were unemployed and because a short course of treatment did not give enough time for change to occur. A longer treatment program or a follow-up evaluation would be needed to determine if improvements in work functioning and OCD symptoms increase over time. This study demonstrated that the benefits of CBT extend beyond OCD symptom reduction to improvement in quality of life.

D-Cycloserine augmented exposure therapy for obsessive-compulsive disorder

Biological Psychiatry, 62:835-838, 2007, M.G. Kushner, S.W. Kim, C. Donahue et al.

Animal and human research have shown D-cycloserine (Seromycin) can increase extinction learning involved in exposure therapy to reduce fear. Ideally, D-cycloserine would make it easier for exposure therapy to work, there would be a faster response, and patients would be more motivated to continue behavior therapy. In this double-blind study, D-cycloserine (125 mg) or placebo were given to individuals with OCD approximately 2 hours before each exposure session. After 4 weeks of exposure therapy, the 15 patients taking D-cycloserine had a significantly greater response than the 17 patients taking a placebo pill. However, after 10 weeks of exposure therapy, the responses were similar. We reported a study in the Fall 2007 OCF newsletter in which D-cycloserine did not enhance behavior therapy for OCD and interestingly, treatment response was measured after 12 weeks of therapy (E.A. Storch et al., *International Clinical Psychopharmacology* 22:230-237, 2007). This study did mention that D-cycloserine

might lead to greater improvements than placebo earlier in treatment. Augmenting behavior therapy with D-cycloserine may reduce the number of individuals with OCD dropping out of treatment early.

Clinical predictors of response to cognitive-behavioral therapy for obsessive-compulsive disorder

Clinical Psychology Review, 28:118-130, 2008, M.L. Keeley, E.A. Storch, L.J. Merlo et al.

Authors reviewed predictors of treatment response in clinical trials of cognitive-behavioral therapy (CBT) for OCD. Although there were inconsistent findings in much of the literature, several relatively consistent predictors were identified. Greater OCD symptom severity predicted a worse treatment outcome. Possibly extending the length or intensity of CBT for individuals with more severe symptoms may be helpful and research is needed on augmentation strategies for these individuals. Symptom subtypes are factors, specifically individuals with hoarding and sexual/religious obsessions have had poorer CBT response. Co-occurring (comorbid) severe depression may be a predictor of poor treatment response. Presence of certain personality disorders or traits affect outcome negatively, although studies differ with regard to which personality traits are predictors. The most consistent evidence is for schizotypal personality traits to affect outcome adversely. Research indicated a consistent relationship between family dysfunction and treatment response, especially a negative effect of hostility and criticism by family members. A positive therapeutic alliance between patient and therapist affects treatment outcome positively, suggesting training of therapists who implement CBT should include a discussion of therapist behaviors that promote a positive alliance.

Symptom relapse following switch from Celexa to generic citalopram: an anxiety disorders case series

Journal of Psychopharmacology, 21:472-476, 2007, M. Van Ameringen, C. Mancini, B. Patterson et al.

Generic drugs are sold at substantially lower prices, mainly because companies do not need to cover high costs of original research studies required for brand name drugs. Generic drugs must be the same as the brand name medication, in terms of identical active ingredients, dosage form, strength and route of administration. Also, generic drugs must have a bioequivalence (absorption measured by blood lev-

els) that is similar to the brand name drug. In the U.S., bioequivalence must fall within a range of 80% to 125% of the brand drug. This moderate variation in bioequivalence is not thought to be clinically meaningful, however, there are reports of lack of therapeutic equivalence between some generic and brand medications. At the Anxiety Disorders Clinic, McMaster University Medical Centre in Canada, approximately 172 patients with anxiety disorders were switched from Celexa (brand name citalopram) to generic citalopram. Only twenty patients (12%) experienced difficulties. This study examined response and side effects with the generic in these 20 patients, eleven of whom had OCD.

Worsening of anxiety symptoms occurred, as well as physical complaints such as gastrointestinal problems and headaches, within an average length of time of 3 weeks after the switch. All patients re-established previous treatment response with a change back to Celexa. It is important for physicians to be aware of the potential loss of treatment effect with a switch to a generic drug. This is not limited to the generic citalopram, but has been reported with other selective serotonin reuptake inhibitors (SSRI) generics and medications in general.

Repetitive transcranial magnetic stimulation for the treatment of obsessive compulsive disorder: a double-blind controlled investigation

Psychological Medicine, 37:1645-1649, 2007, P.S. Sachdev, C.K. Loo, P.B. Mitchell et al.

Repetitive transcranial magnetic stimulation (rTMS) is an experimental treatment of brain stimulation with an electrical current. An electromagnetic coil is placed on the scalp. A high-intensity current is rapidly turned on and off (repetitive) in the coil and this produces a magnetic field that passes painlessly to targeted brain tissues. In this double-blind placebo-controlled study, 18 patients with treatment-resistant OCD were randomized to receive rTMS (n=10) or sham rTMS (n=8) for 10 sessions of daily stimulation over the left dorso-lateral prefrontal cortex of the brain. For sham (placebo) stimulation, an inactive coil was placed on the subject's head. Side effects of rTMS were headache, localized scalp pain during the session, facial nerve stimulation during the session, feeling dizzy/faint and weepiness. The two groups did not differ in severity of OCD symptoms over the 10 sessions. Over 20 sessions, the open extension of the study, there was a significant reduction in OCD symptoms, but not after controlling for depression. The conclusion, rTMS was ineffective for treatment-resistant OCD. Researchers state results could be different in patients not resistant to standard OCD treatment. However, it is unlikely that these individuals would be treated with rTMS, which can be uncomfortable and requires daily attendance at a hospital or clinic.

Hypnotize Away My Obsessions

By James Claiborn, Ph.D.
South Portland, Maine

I spend a lot of time answering questions about OCD and frequently get asked about hypnosis as a treatment option. After all, people ask, they have heard that hypnosis helps with problems like smoking which seems compulsive; and obsessions seem irrational so why not just have someone remove them with hypnosis. The short answer is that hypnosis has not been found useful in treating OCD and there are a number of reasons to think it is not likely to be useful.

To understand why hypnosis is not the treatment of choice we can start with understanding more about hypnosis itself. The definition of hypnosis is the subject of considerable debate. Careful research has not been able to establish any specific characteristics or experiences that make it a distinct state. Hypnosis seems to involve focused attention and perhaps some increase in suggestibility that can be explained by the individual's motivation and expectations. No one has ever demonstrated any effect of hypnosis that could not be produced under other conditions.

The second issue in understanding the use of hypnosis is that by itself it is not a treatment. While there are standard ways to produce this so called state, there is a very broad range of procedures and approaches to therapy that might be applied in the context of hypnosis. The result is that there is no way to say if hypnosis per se would work for OCD and the question becomes would it facilitate treatment. The only psychological treatment for OCD that has been found to work reliably is cognitive-behavioral therapy. There is an extensive body of research showing exposure and ritual prevention work well for OCD.

In recent years researchers have shown more cognitive approaches are also effective in treatment of OCD. Clinical

experience supports the generalization from research settings and supports the idea that in the hands of a well-trained therapist CBT proves to be a very effective treatment for OCD. Other psychological approaches to therapy, often called talk therapy, have not been subjected to careful testing in the treatment of OCD; but accumulated experience has led most experts to conclude that it is not an effective way to treat OCD. It follows that adding hypnosis to some otherwise ineffective treatment is unlikely to change the picture.

One of the common treatment methods used in the context of hypnosis is direct suggestion. The therapist using hypnosis may suggest that the patient forget, feel disinclined, or simply have no desire to engage in a specific behavior. If this works, it is probably because the person believes that somehow hypnosis has made this change occur. If we applied this to engaging in a compulsion it might lead to some ritual prevention and possibly help control OCD. The disadvantage is that the person might attribute the improvement to hypnosis rather than his/her own effort. Direct suggestion might be used to tell the patient that s/he would no longer have his/her obsessions. However, this is unlikely to work any better than the person trying to suppress obsessions that leads to an increase in obsessing.

Some therapists do combine hypnosis with CBT. To date there is no research suggesting that this combination is any more effective than standard CBT. If expectations make a difference and the patient has high expectations for hypnosis, this combination may be of some value. Realistically, if you want help with OCD the best option would be to seek a proven treatment. Since CBT has been proven to be the most effective treatment for OCD, it is logical to look for a therapist who can provide it. If you want to try hypnosis, look for someone who will combine it with standard CBT.

UNC Clinic Offers Affordable Intensive Treatment: An Interview with Jonathan Abramowitz, Ph.D.

NEWSLETTER: The University of North Carolina (UNC) at Chapel Hill has a new clinic for the treatment of anxiety and stress. Is OCD treated at this clinic?

DR. ABRAMOWITZ: First, thank you so much for spotlighting our new program in the Newsletter. We are very excited to get the word out about our services.



Dr. Jonathan Abramowitz

Now, to answer your question, yes we work with people who have OCD. In fact, you might say OCD is the “specialty of the house.” I have dedicated my career to treating this problem, training others in how to use effective treatments, and researching OCD.

NEWSLETTER: Where is your clinic located? Can people get there using public transportation?

DR. ABRAMOWITZ: We actually have two locations in the Chapel Hill, NC area. One of these is on the UNC campus in the Psychology Building (Davie Hall). This site mainly serves the UNC campus community. Our second location, which is conveniently located off of Raleigh Rd. in Chapel Hill, serves the Raleigh-Durham-Chapel Hill community. This clinic is close to Interstate 40 and approximately 15 minutes from the Raleigh-Durham International Airport. It is about a 20 to 30 minute drive from Raleigh and about a 2-3 hour drive from Charlotte. The off-campus site serves the Raleigh-Durham-Chapel Hill area and we have had people travel for treatment from all over the southeast U.S. and beyond.

NEWSLETTER: What treatment modalities are used at your clinic to treat OCD?

DR. ABRAMOWITZ: We use cognitive-behavioral therapy (CBT) – specifically, the techniques of exposure, response prevention, and cognitive therapy.

NEWSLETTER: Are these treatments evidence-based?

DR. ABRAMOWITZ: Yes, CBT for OCD has been very well studied over the last 30 years. These studies consistently show it is the most effective way to reduce obsessions and compulsions. It is more effective than “talk therapy,” relaxation training, stress management, and

even more effective than serotonin reuptake inhibitor (SSRI) medication. I tell people who come to our clinic that, on average, about 60% of people who complete a course of CBT show about a 60% reduction in their OCD symptoms. In addition, CBT gets results fast – the improvements are seen in as few as 15 treatment sessions. Another advantage of CBT is that we know it has good long-term effects. This means even after you stop seeing your therapist, you are likely to continue doing well. I think this is because in CBT you learn and practice skills for beating OCD that no one can ever take away from you. You can use them for a lifetime.

NEWSLETTER: Can you explain CBT and exposure and response prevention, and tell us how they work on OCD?

DR. ABRAMOWITZ: Sure. CBT is based on weakening the maladaptive thinking and behavior patterns that are involved in obsessions and compulsions. You learn and practice techniques that weaken the pattern of becoming very anxious over obsessional thoughts and situations and skills to weaken the pattern of using compulsive rituals to deal with anxiety.

We think of CBT as involving four techniques. The first is education, which means that you learn about how your obsessions and compulsions are related and how CBT is used to reduce these symptoms. Another technique is called cognitive therapy, which involves helping you identify and correct problematic thinking styles that lead to anxiety – for example, the tendency to exaggerate risk and uncertainty. The two most powerful techniques in CBT, however, are exposure and response prevention. Exposure means gradually confronting the situations and thoughts that trigger obsessional fear. Exposure can involve actually confronting feared situations, or imaginal exposure to feared disasters. Response prevention means that you practice staying in the situation until the anxiety decreases on its own, rather than escaping by doing rituals. By practicing exposure and response prevention, a person with OCD learns that anxiety eventually lessens the more he or she remains exposed – even when no rituals are performed. This is called habituation. So, exposure helps reduce obsessional anxiety and response prevention helps you to weaken the pattern of using rituals to reduce obsessional anxiety.

NEWSLETTER: That seems like hard work!

DR. ABRAMOWITZ: Well, it often is hard work. I explain to people who come to our cen-

ter that they will almost definitely feel uncomfortable during exposure sessions. But, that we also work with our patients to help minimize their distress and help them get through it. Specifically, we encourage the person to start with exposure to less distressing situations and gradually work up to more challenging ones. We also help the person to see that the anxiety is only temporary. It subsides as time goes by. So, as you might have guessed, how much improvement a person gets out of CBT is related to how much effort he or she puts into doing the therapy.

NEWSLETTER: Is your clinic outpatient or inpatient?

DR. ABRAMOWITZ: Our clinic is an outpatient clinic only.

NEWSLETTER: What is the normal course of treatment for someone in your clinic? How many sessions a week? Typically, how long will someone continue exposure and response prevention therapy? Is the length of therapy dependent on the particular person who is being treated?

DR. ABRAMOWITZ: The course of treatment depends on a number of factors, most importantly, the nature of your OCD symptoms. At the initial visit to our clinic, patients receive an evaluation and consultation in which we thoroughly assess the OCD symptoms and psychological history, and make recommendations about what is the best way to proceed with treatment. Typically, the actual OCD treatment program is about 15-20 sessions with the therapist, but this is flexible. These therapy sessions might occur once a week, twice a week, or even more frequently depending on the severity of the OCD symptoms and the patient’s schedule. The sessions might last anywhere from 1 to 2 hours.

NEWSLETTER: Do you have an intensive treatment program?

DR. ABRAMOWITZ: Yes. When the OCD reaches a severe level, we recommend intensive treatment, which means daily treatment sessions (Monday through Friday) for three weeks. In addition, patients who come from out of town typically do the intensive treatment schedule to minimize their time away from home.

NEWSLETTER: Could you describe your intensive treatment program? Who is eligible for it? How long is it? What treatment modalities do you use for patients in your intensive program?

DR. ABRAMOWITZ: The intensive treatment program is a 3-week version of our typical treatment for OCD. It consists of 15 daily sessions (M-F) of outpatient therapy that begins with two or three initial sessions of assessment and treatment planning. The remaining sessions involve practicing exposure, response prevention, and cognitive therapy with the therapist's supervision and assistance. Between sessions, patients are asked to continue their exposure work as well.

Eligibility for the intensive program is determined during the initial evaluation. Most people with OCD are eligible, unless there are serious complicating factors that make CBT inappropriate (such as being actively suicidal or having trouble with substance abuse). This evaluation can be done in person or over the phone, if the person lives too far from Chapel Hill.

NEWSLETTER: Do you have residential facilities for individuals in your intensive program? Are there hotel facilities nearby that a patient could stay at during the course of the intensive program? Where are they and what are they?

DR. ABRAMOWITZ: Unfortunately, we do not have residential facilities in our treatment clinic. However, there are hotels nearby where our out-of-town patients typically stay during their treatment. These are listed on our website at www.uncanxietyclinic.com; or we can mail you a list if you call us. Some patients who have come here from out of town have negotiated to rent an apartment or townhouse for the three weeks they are here. However, I'm not exactly sure how this was done.

NEWSLETTER: Do you involve family members or a significant other in your treatment program? How do you integrate them into the sufferer's actual treatment?

DR. ABRAMOWITZ: If you have a family member or significant other who is interested in helping you out with treatment, we certainly welcome this. In fact, one of the research studies currently underway in our clinic involves developing a couples-based therapy for OCD. So, if you have a spouse or partner who is willing to participate in treatment, you might even be able to participate in this study and receive free treatment.

We integrate significant others into treatment by having them attend some of the treatment sessions to learn how to be a good coach and cheerleader for the patient. We might teach the significant other to assist with exposures, or work with a couple to help them learn more healthy ways of relating around the OCD symptoms. For example, we might help a couple communicate more effectively about their needs and wants when it comes to the OCD symptoms.

NEWSLETTER: Do you treat only adults or

do you have programs for children and adolescents?

DR. ABRAMOWITZ: Presently, we only evaluate and treat adults in our program.

NEWSLETTER: Who is on the staff of your OCD treatment program? Can you tell us about their background, training and experience? What is your background, training and experience?

DR. ABRAMOWITZ: I am the director of the anxiety and stress disorders clinic. The other members of our staff include Ph.D. level, Masters level, and Bachelors Degree level therapists. Most of our therapists are advanced graduate students working toward their Ph.D. in clinical psychology. The UNC clinical psychology training program is among the top 10 best programs in the U.S., so our therapists are outstanding. They operate under my close supervision and, as I like to say, work very hard to impress me in order to get good grades!

All our staff have been trained in the use of CBT for anxiety and OCD. They receive intensive training by observing therapists conducting treatment, and then by conducting therapy themselves under close supervision. Their level of experience ranges from one year to several years. As for me, I am an Associate Professor and the Associate Department Chair of Psychology at UNC. I have been treating people with OCD for over 10 years and am a licensed clinical psychologist in North Carolina. I earned my Ph.D. in clinical psychology from the University of Memphis in 1998 and also trained for three years at the Center for Treatment and Study of Anxiety in Philadelphia under the supervision of Drs. Edna Foa, Michael Kozak, Marty Franklin and others. In 2000 I moved to the Mayo Clinic in Minnesota to start an OCD/anxiety disorders program, which I directed until 2006 when I moved to UNC.

I have treated and evaluated hundreds of people with OCD, and I routinely give workshops to train clinicians. Our OCD program, in fact, serves as a place for students and professionals to learn about the treatment of OCD. I'm also a member of the Advisory Boards for the Anxiety Disorders Association of America and of the Obsessive Compulsive Foundation, and am on the Board of Directors of the Association for Behavioral and Cognitive Therapies. Finally, I have written and edited numerous books and research articles on OCD and its treatment.

NEWSLETTER: Is medication part of your treatment regime?

DR. ABRAMOWITZ: We do not have psychiatrists or physicians on our staff, and therefore do not work with medications. We find that most of our patients are already taking medication when they come into our program, however. We recommend that you remain in contact with your psychiatrist or other physician to manage your

medications.

NEWSLETTER: Do you work with the OCD spectrum disorders at your clinic?

DR. ABRAMOWITZ: In addition to OCD, we work with other anxiety disorders, as well as severe health anxiety (hypochondriasis) and body dysmorphic disorder (which are sometimes referred to as spectrum disorders).

NEWSLETTER: Are people with comorbid conditions, such as, depression, PTSD or bipolar disorder, eligible for your treatment program? Are people with substance abuse problems allowed to participate?

DR. ABRAMOWITZ: People with OCD often have other co-occurring problems, such as, depression, anxiety disorders, bipolar disorder, and substance abuse. At the initial consultation visit, we assess for these problems and use our expertise to make a determination about whether they might interfere with therapy to the extent that a different referral is necessary. In some cases, we elect to proceed with OCD treatment. If, however, it appears that the secondary problem will get in the way of the OCD treatment, we try to provide a referral for the necessary services before working on OCD.

NEWSLETTER: What do you do about relapses? Can someone come back into the program or can s/he come back on a non-intensive schedule?

DR. ABRAMOWITZ: Once someone goes through our program, the door is always open. Occasionally, people have difficulty keeping up with their treatment, or they have a setback and need more help. We are happy to provide "booster sessions" in such cases.

NEWSLETTER: This sounds like a wonderful treatment program. What does it cost? Is it covered by private insurance? Do you take Medicare and Medicaid?

DR. ABRAMOWITZ: I am very happy to say that we are able to offer CBT treatment for OCD at an extremely low cost. In fact, we have a sliding scale fee that is based on income. This means we will not turn anyone down for treatment simply because s/he cannot pay. We will work out an affordable fee. There is a standard fee for the initial consultation (which is a 2-hour appointment), and this is often reimbursable by insurance companies. We do not take Medicare and Medicaid, but again, will work with you to set a fee you can afford.

NEWSLETTER: If someone would like more information about your program, what's the best way to get additional information?

DR. ABRAMOWITZ: Our clinic has a website: www.uncanxietyclinic.com, which also has our brochure. Our clinic phone number is 919-962-6906. Finally, I am happy to answer questions about the program if you call (919-843-8170) or e-mail me directly at jabramowitz@unc.edu.

My Last Adventure

(continued from page 1)

I wasn't going to be working in the New Haven office that last day. I had made arrangements to go to the Boston office and help unpack the stuff I had packed. By the number of boxes the movers had carried in and the legal size containers of gently used manila and hanging files, someone familiar with OC spectrum disorders would have labeled the drive behind this as compulsive hoarding. But that is a debatable diagnosis. What's important (to me) is to tell you about my last adventure as OCF's ED.

I overslept, lost the cat, and medicated the dog and then myself. I decided to add one more anaftranil to my usual medication cocktail. Of course, I could have practiced a little exposure and response prevention instead of jumping out of the car while the engine was still running to recheck that the toaster oven was definitely off. After all, Dr. Maltbe had spent a lot of time and energy getting me to recklessly throw tree branches into the road and to drive very close to pedestrians in mall parking lots. There was no checking in the rear view mirror with Dr. Maltbe on my case. He was just as dictatorial about my stopping the car and going back to see if I had, actually hit and killed the pedestrian I had just driven by. You people with OCD know what I'm talking about.

Then, I went to the local gas station where all the pumps were in use. Patience is not one of my qualities, but this missed opportunity to get gas will play a bigger role later in this story. I noted it was 8:09 a.m. when I exited the gas station. This is important too. I usually started for work at 7:50 a.m. This meant I was off schedule. I wanted to stop at the old Foundation office in New Haven to give Jeannette my office keys, hug Daisy, and say not good-bye, but "I'll call you later."

At this point, I noticed that a lot of nonspecific anxiety-laced thoughts were breaking through the anaftranil wall that I had ingested earlier. I needed to hurry. This is a double bind for a person with my type of OCD. You can't go over the speed limit, but you have to be on time. Not being able to resolve this myself, I opted for Jeff Bell's Greater Good (see Vol. 21, Number 6 of the OCD Newsletter). Solution: I sped down I-91 half the time, and the other half of the time it was drive sixty-five. I mention this as a prelude to what happened next.

At Exit 12 (I'm aiming for Exit 4), the traffic stopped. There was a wicked (see how I have picked up Boston slang already) traffic jam. I inched along with everyone else for 20 minutes and got to Exit 7 and 8. Don't ask – it's a Connecticut thing and a positive reason for moving the Foundation to Boston. I got off at Exit 7 & 8. I know this exit: I used it when the Foundation was located in North Branford. Unfortunately, there was gridlock on the exit ramp too. Time was passing.

Let me just interject here that the Boston train I wanted to be on was scheduled to leave New Haven at 10:10 a.m. And don't even ask why I was going south when Boston is north of my home. I usually don't have an OCD problem with counting and numbers, but when I realized how long it had taken me to get here from there, I started compulsively repeating 10:10. Then I took a wrong turn and headed north instead of south. For the next 15 minutes I drove down streets I didn't recognize, trying to find New Haven. I asked directions from a lot of pedestrians and actually started a fight between a husband and wife about which traffic light I should make a turn at. I stopped counting and started to think "what ifs...." What if I don't find New Haven, what if I don't have time to stop and see Daisy and Jeannette, what if the landlord called the police about the fact that I hadn't turned in my key?

But I finally got there. Parked my car practically on the yellow line running down the middle of the street – my parallel universe does not include parallel parking – and ran into the office. I gave the keys to Jeannette and admonished her to get them to the landlord so I wouldn't be arrested. Then the anaftranil kicked into gear and took over the situation, but in a bad way. I had sudden and complete dry mouth, and I was having trouble remembering what I wanted to say to them on this our last day. Jeannette saw what was going on, said she'd get the keys to the landlord, and that she had unplugged the coffee maker so I didn't have to obsess about it malfunctioning and burning the building down. Jonathan Grayson would not have approved, but he didn't have to be at the train station in 23 minutes. Not everything is enabling!

I hopped back into the illegally parked car and hit every red light from 676 State St. to the train station. Now, I had to find a place to park. The train station garage was full, the outside parking lot was full, even the multi-floored parking garage across the street was full. The only parking spaces left were in an unprotected street level parking lot that was a good 8-minute run to the train station if you had been training for a marathon and weren't old. I parked there and paid the man, then started to run in the direction of the train station.

Let's review the time frame now. I had 23 minutes after I left 676 State St. to get to the station, buy a ticket and board the train. I spent 11 of those minutes racing to the station and finding a parking space. That left me with 12 minutes to get to the station, buy a ticket from an unmotivated clerk who sold tickets in slow motion and board the train that, of course, was on the outermost track. This was not a good thing, because I don't ever exercise, my right foot was hurt, I was dragging a stuffed purse in one hand and a full tote bag in the other and, most importantly, I'm old.

I got to the station doors with four minutes to get some water (dry mouth still hanging on even though the anaftranil had other places it was supposed to be going in my system), purchase a ticket

and get on the train. Would I make it or would I have to stay in Union Station for four hours without a decent book to read? The answer was yes, but with a hitch. The Boston-bound train, my train, was 40 minutes late according to the departure information on the station's big board. So all the rushing around was for nothing.

In celebration of almost having a heart attack, I bought, not one, but two glazed doughnuts and proceeded to inhale them. The train was actually 50 minutes late, but as I waited the wheezy chorus in my chest went away, and I could breath on my own. My brain, sensing a lot of synapses firing incorrectly, decided to use the wait time to make me do a little obsessing and maybe a few compulsions. Suffice it to say you can find a lot of OCD-inducing situations in a public bathroom.

Unfortunately, the rest room situation was a petri dish of OCD triggers, starting with the wet floor and moving on to the broken toilet paper holder in my stall. There was no front cover on it. Yeah, you can see what's coming next. While I was unrolling it, the paper roll fell on the "wet" floor. Alright, a little damp. Let me tell you something that you might not know if you don't have OCD – the fallen and now wet paper was completely contaminated. You can't wash toilet paper, so that solution wouldn't work. I needed to be able to decontaminate the roll or put it somewhere where no one would touch it and be contaminated. That's when the scrupulosity started. I couldn't just dump it in a trash can because it was the station's property, and going vigilante wasn't my style.

Then in the warped way my brain on OCD works, I came up with the perfect solution. I took it to the custodian in the custodian's closet and told her the roll I had in my hands had fallen on the floor. She looked at me with distrust and then put the roll down. Solved two OCD compulsions at once. No, not really. I then had to wash my hands again. While doing so I spotted the custodian putting the roll I had given her back where it had fallen from.

Luckily, my train's departure was announced, so I didn't have time to explain to her that the roll was contaminated and by putting it back she was exposing travelers to contamination and possibly death. I'm sure if I had told her that she would have called one of the transit cops.

The train ride was long and boring, so I kept going into the lavatory and washing my hands. Just a little busy work.

I eventually arrived in Boston and found a cab to take me to 112 Water St. – the OCF's new home. It was a little after 1:00 p.m.; I had been obsessing for five hours.

Joy Kant was already there, so we got right down to unpacking boxes, putting the contents away and throwing out the stuff that should have been thrown out when we were packing these cartons up. It appears that there had been some undiagnosed compulsive hoarding going on in New

Haven. No one can arbitrarily claim that I really didn't need to send 13 copies of the OCF's 2002 Financial Statement. There could be a time that 12 would just not be enough. I think I heard Joy, under her breath, say, "Thank God that Gail Stetekete is just a cab ride away."

That's when I started throwing stuff away with gay abandon. As I dropped an opened staple into a box where we were throwing stuff that needed to be shredded, it dawned on me that I didn't have any obsessions or compulsions bugging me. It did occur to me that the staple could have had a deadly virus on its prongs and some innocent soul might put his hand in there and get pricked and subsequently die. But it didn't bother me. It was just a thought. Could it be that getting really into something else might exorcise OCD? I'll leave that question to all the OCD researchers out there.

We unpacked and stacked and answered the phones. We assigned files and binders to their new homes. An office was beginning to emerge from all those moving boxes. I left at 5:30 for the train. I found a cab right away, bought my ticket with time to spare. I even had dinner – a yellow bag of peanut "M&Ms." And, I washed my hands four times and used a crumpled up bag on which I had poured Poland Spring sparkling water to clean off the table that I was using. There's an explanation for this: I had put my bag on the floor before I put it on the table. So I needed to inconspicuously decontaminate the table before some unknown person contracted an incurable disease from the bottom of my bag. I tried to convince myself that I was just a good citizen looking out for the health of others.

The train was a little late, but by that time I had bought a book and was reading it in my recently decontaminated environment. I had scrubbed the chair down (inconspicuously, of course) with a germ-killing handi-wipe. One part of me wanted to wash the table more thoroughly. The other voice, the one I had been paying attention to all afternoon at the OCF office, told me right up front that I was obsessing and getting dangerously close to performing a ritual.

I boarded the train and seated myself near the restrooms. Fortunately, someone sat beside me so I couldn't get up without apologies and explanations. The result of this serendipitous seating plan: hands washed just once. I don't know whether to thank the anafranil or the woman on her cell phone sitting between me and the aisle.

From here it gets a bit trickier. The train seemed to stop in every town in Rhode Island. Luckily it's a small state. I hadn't asked when the train was scheduled to arrive in New Haven, so consulting my watch every two minutes really didn't move the train along any faster.

Two hours into the trip maybe I dozed a little, but I did wake up quickly when I heard the conductor saying, "Next stop, Stamford." Still a little dazed I sat in my seat watching as the New Haven train station disappeared into the night. Now I had a

real problem that washing my hands wouldn't help. My car was in New Haven and Stamford is forty minutes away by express train. With no grace whatsoever, I crawled over my seatmate and ran down the aisle calling to the conductor. (I went to Catholic School, so I always turned to authority figures when I've really screwed up.)

He was helpful when I caught up with him in the bar car; he didn't laugh, but told me to sit down at one of the tables and gave me a handful of "M&Ms" to eat while I made the 40-minute ride from New Haven to Stamford and the 40-minute ride from Stamford to New Haven. When we reached Stamford, there was a 5-minute window to catch the New Haven train. I didn't stop to wash my hands or to find a transit policeman and tell him there was some unattended baggage in the station (I had done that on another trip back from Boston). The only thought in my head was how I was going to get up, over and down to Track 5 in the allotted time. Remember, at the beginning of this tale I told you I was old and didn't exercise much (actually, not at all).

My hurting right foot, my stuffed handbag, and the very heavy tote bag arrived on a train siding, but there was no sign saying which track it was. Now I know Drs. Mansueto, Pollard and Gorbis would call what I did next "reassurance seeking." But, I'd challenge them on that conclusion – I only asked the couple waiting on the platform if this was, indeed, Track 5, twice. It was and I got on the train after asking one of the conductors who was herding passengers into the train if this was the train to New Haven, twice.

Yada, yada, yada, I got back to New Haven at 11:05 p.m. Now I had to go out into the frigid night without hat or gloves (don't ask; they were in the dryer after a potentially contaminating run-in with a garbage bag). While dragging my stuff, myself and my right foot, I noticed a couple of couples that looked like they were heading somewhere. I counted to 10 and followed them out the station door. Just as I was beginning to think they would lead me to my destination, they got into a car and drove away, leaving me alone to retrace my morning run from the parking lot.

Then under lots of very tall lampposts that gave very little light, I recognized my parking lot. It was almost empty. The space was dark and scary. It was hard to distinguish the makes and models of the cars there. But, it was indeed my lucky day – off to the back of the parking lot, I pick out my silver RAV4 because its lights were on. I was able to staunch the anxiety attack that had been building by telling myself that if the lights were on (and I didn't need to check twice to confirm this), then the battery wasn't dead. I was right but for the wrong reasons. In my mad dash to catch the train, I had left the car running.

Dismissing any rituals, such as, checking whether the car had gas or not, I tried to find my way out of the parking lot and onto I-91. I was stopped by two cops who wanted to know why I had left the

lights on all day. My reply was I have OCD. They quickly stopped laughing and pointed me toward the highway.

I was feeling good; I was finally on the last lap. As I got on the ramp to I-91, I saw a bright light flash on the dashboard. It was that cute little icon of a gas pump. Oh, yeah! Ms. Check had failed to check to see if the car had enough gas to drive the 40 or so miles it takes to get home. Not only wasn't there enough gas to get home, there probably wasn't enough gas to get to a gas station.

Not to worry, because this was a real problem, not OCD. I'd go to Exit 7 & 8 (see explanation above) get off, and go to one of the many gas stations on Route 83. I coasted along for several miles, finally seeing the dim outline of gas pumps. I turned in and drove right up to the pump. The fact that the station was not lit up made no impression on me. Things were going really well; unlike this morning, I could have pulled up to any of the pumps. I got out of the car, released the gas cap and plugged in my credit card. The pump did its thing, asking whether this transaction was going to be debit or credit, telling me to put in my card and pull it out quickly, directing me to chose what kind of gas I wanted and instructing me to put the nozzle in my gas tank and start pumping. Being an OCD rule-player, I did everything the pump had commanded me to do and I was able to pump \$.26 worth of gas. Funny thing, not all gas stations stay open all night. Just to prove it, I stopped at two more poorly lit stations. From each I got \$.26 worth of gas and a sinking feeling that I might not be able to drive the forty odd miles I had to cover to get home.

So after using most of the little gas I had and probably some of the gas I had just purchased, I decided to get back on I-91 and head north. I also checked to make sure I had my AAA card in my wallet and it hadn't expired and my cell phone was charged. The irony here is almost too obvious – I'm a checker who checks everything but what I should.

I prayed and kept my foot off the gas for the 16 miles to Meriden where there is a large service station. I did not play "what if" because this was a real problem. While still on the off ramp, I caught sight of the gas station; it was lit up inside and out. I coasted in on momentum. I put in my card and pumped 12 gallons of gas (the full capacity of my tank).

Then I proceeded to drive home. I was tired and so was my OCD. Nothing untoward happened on this part of the trip.

So this is the adventure I had on my last day as the executive director of the Obsessive Compulsive Foundation. What's the importance of telling you this tale? At the beginning I told you that this was a cautionary story. The point is to take your medication faithfully, but rely totally on Exposure and Response Prevention to get you home.

Ciao! I'll miss all of you.

OCD and Tourette Syndrome

(continued from page 1)

behaviors (compulsions) that the person feels compelled to perform in response to his/her obsessions. Typically, these are designed to reduce distress and/or to prevent a feared event. Tics are sudden, repetitive, stereotyped movements or phonic emissions that are usually seen as involuntary and are sometimes preceded by urges. Tics can occur in flurries and tend to wax and wane in severity and intensity over time. They can be simple – sudden, brief and meaningless (e.g., eye blinks, head jerks, facial grimaces, coughs, barks, snorts, etc.) or complex, slow, and more purposeful (e.g., smelling things, touching things, shouting obscenities, counting things, tracing objects, “evening up” objects, and repeating heard words or phrases, etc.). Simple tics often appear first with complex tics developing later. Tourette Syndrome is diagnosed when multiple motor tics and one or more phonic tics are present during the course of the disorder.

OCD can begin at any age but most typically it begins in early adulthood in females and somewhat earlier in males. The course of the disorder can vary greatly from individual to individual, but in most cases OCD persists into adulthood, though waxing and waning in severity. Among the more common comorbid conditions are depression, other anxiety disorders, eating disorders, and TS.

Tic disorders typically begin in mid-childhood and peak during early adolescence, and, like OCD, usually rise and fall in severity over the years. By adulthood tics tend to abate or be absent entirely. In 15% of adults, tics continue to present moderate problems, and 10% experience severe problems with tics. Prediction of the course of the disorder in any individual child is impossible. While the tics themselves can be problematic enough, many individuals with tics and most people with TS have features associated with a wide variety of other disorders. Among the more common features appearing in conjunction with tics are: impulsivity, inattention, hyperactivity and restlessness associated with ADHD; the behaviors and obsessive compulsive thoughts associated with OCD; the difficulties in learning associated with LDs; the emotional lability, irritability, anger and aggression associated with mood disorders and oppositional defiant disorder; the fearfulness, avoidance and clinginess associated with anxiety disorders; the guilt and helplessness associated with depression; and the sensory integration issues (e.g., oversensitivity to textures, smells, noises, light) associated with sensory processing problems. The majority of children with TS have symptoms of one

or more associated conditions. Those children are said by some experts to have “TS Plus”.

OCD and TS exist as separate entities according to the current Diagnostic and Statistical Manual of Mental Disorders (4th Edition) – DSM-IV. OCD is classified as an anxiety disorder while tic disorders, including TS, are among “Disorders Usually First Diagnosed in Childhood.” The currently favored treatment approaches, both pharmacological and psychological, for OCD vs. T/TS also differ. For OCD the psychological treatments of choice are the cognitive-behavior therapy (CBT) techniques of exposure and response prevention (ERP) and cognitive therapy (CT), while pharmacological treatment favors the serotonin reuptake inhibiting family of antidepressants, selective and non-selective (SSRIs, SRIs) and a variety of augmenting medications. Tics/TS, on the other hand, tend to be treated by the CBT techniques of contingency management, relaxation training, and habit-reversal training (HRT). Medications favored for treatment of T/TS are standard neuroleptics (e.g., haloperidol, pimozide) and atypical neuroleptics (e.g., risperidone, olanzapine) and alpha-2 agonists (e.g., clonidine, guanfacine). OCD and T/TS have also been viewed as distinctly different entities on the basis of differing courses as well as presumed etiologies.

Yet despite the distinctions outlined above, there is substantial evidence that OCD and T/TS overlap in ways that suggest a much closer relationship. The frequent concurrence of symptoms of both disorders in the same individual is one strong clue. Up to 60% of TS sufferers have been reported to have OCD symptoms, 50% of children with OCD are reported to have had tics, and 15% met criteria for TS. Also, evidence from family studies and lines of genetic research suggest that the disorders are etiologically linked.

Moreover, at the clinical level, distinguishing between OCD and T/TS symptoms can be difficult and at times impossible. Even seasoned experts can be hard put to distinguish complex tics from compulsions. This can present a significant dilemma for clinicians attempting to make a differential diagnosis (tic or compulsion?) under such circumstances. This is not a small point. Besides influencing treatment decisions, the diagnosis holds important implications for the predicted course of the patient’s disorder, the likely choice of treatment, and the expected prognosis for the individual.

So at this stage of the clinical science and art, there are strong indications of an interplay between OCD and T/TS, suggestive of a tantalizing relatedness. Yet there continue to be formal barriers to a clearly elucidated conceptual framework that would clarify the relationship between these disorders and that would provide pathways for practical solutions to

frequently encountered clinical problems.

In the remainder of this article I will offer perspectives on the relationship between OCD and T/TS based upon years of clinical experience with these disorders. My colleagues at the Behavior Therapy Center of Greater Washington and I are convinced that our adoption of perspectives described here has greatly facilitated our understanding of the nature of the problems confronting our patients and our efforts to provide the most effective treatment possible. My hope is that broader efforts to understand OCD and its variants and to develop more effective methods to help sufferers and their families might be enhanced by consideration of these views. Moreover, I have seen patients and their families take comfort in the perspectives outlined below, struggling to understand the perplexing array of symptoms that can occur at the interface of OCD and T/TS. It is my hope that others might similarly benefit if these ideas were more widely dispersed. Finally, I hope that the broader scientific effort to understand OCD in all of its manifestations may benefit from these insights drawn from clinical observation and practice.

Tourettic OCD (TOCD)

Current conceptual formulations regarding the OCD and T/TS relationship provide minimal practical utility for clinicians, especially for non-specialists, in everyday clinical practice. As mentioned above, boundaries between symptoms of OCD and T/TS can be blurry, especially with regard to differentiating complex tics from compulsions in cases where actions are repeated specific numbers of times, according to prescribed rules, or until a “just right” feeling is achieved. This symptom cluster is not uncommon, yet it is often peripheral to discussions of OCD and its treatment. Ascertaining a personal or family history of tics can be useful. The clinical significance of “tic-related OCD” has been well described by Dr. James Leckman and his colleagues at Yale. Yet in clinical practice reliable information of that sort can be difficult to get. Moreover, clinical decision-making in the treatment of such clients has yet to be clearly elucidated. Categorical thinking (tic or compulsion?) and the absence of a coherent and unified perspective on these phenomena can unnecessarily limit treatment options and thereby impede the development of more effective treatments.

In an effort to address some of these shortcomings in the OCD and T/TS literature, my colleague David Keuler, and I have proposed elsewhere (Mansueto & Keuler, 2005) that there exists a clinical subgroup of individuals frequently seen in treatment who present with a distinguishable cluster of symptoms that represent a *blend* of OCD and T/TS features. We argued that these individuals can be readily identified by their *characteristic clinical presenta-*

tion whether or not a personal or family history of T/TS can be verified. We call this subtype “Tourette OCD” (TOCD) and suggest that it is distinct from “purer” forms of OCD because it is heavily influenced by features usually associated with T/TS.

Distinguishing Features of TOCD

Because it is closely akin to T/TS, symptoms of TOCD, like those of many tics are preceded by prodromal sensations characterized by somatic discomfort, not anxiety. Unlike true OCD, in which cognitions (obsessions) lead to an emotional (affective) state and typically, fear of the content of the obsession, TOCD sufferers report discomforting sensory experiences such as physical discomfort in body parts including hands, eyes, stomach, etc., or a diffuse psychological distress or tension, for example, “in my head” or “in my mind.” These localized or general discomforts in the TOCD sufferer tend to be relieved by varieties of motor responses including “evening things up,” doing things to certain numbers, positioning items, touching and retouching things, doing things symmetrically and so on, typically with the requirement that these actions are performed “just so” or “just right” in order to alleviate the somatic/psychological discomfort. Unlike reports of subjective experiences associated with classic forms of OCD, individuals describe a relative absence of fear or concerns about catastrophic consequences occurring should the required actions not be performed. Instead there are likely to be concerns that the discomfort might be intolerable or unending if the actions were left undone or done poorly. Some TOCD sufferers may report a vague sense that “something bad might happen” if required actions are not performed but they typically lack the more elaborate obsessional features of the typical OCD sufferer. Also, the required actions do not function in the modulation of anxiety and/or prevention of catastrophic consequences typical of compulsions in OCD. TOCD characteristic symptoms can appear alone or can exist in combination with classic OCD symptoms. Other writers have noted such clusters of symptoms in clinical populations and have variously referred to them as “cognitive tics,” “sensory-based rituals,” “sensory fulfillment,” and “Factor II OCD.”

Historical Indicators of TOCD

It is not uncommon for TOCD to have been preceded by certain “historical indicators”: early signs of sensory hypersensitivity (e.g., tactile-defensive reactions to clothing tags, seams, scratchy fabrics, confining clothes, etc.); multiple comorbid disorders, particularly attention deficit disorder, learning disorders, impulsivity and emotional self-control issues; a weak response or no response to SSRI monotherapy; and a weak response, no response, or an anomalous response to expo-

sure and response prevention (ERP) therapy. Sometimes, but not typically, symptoms include intrusive sexual, aggressive, or gruesome images.

The TOCD perspective opens the door to a broader range of treatment possibilities than that drawn from an orthodox categorical perspective. Patients with TOCD are seen in our clinic with regularity. Instead of being constrained by the usual treatment recommendations, our patients are likely to receive a mix of therapeutic approaches drawn from both the OCD and T/TS “tool kits.” ERP and cognitive therapy are frequently augmented by relaxation training, substitution strategies like HRT in which required responses are discouraged by practice of responses that are incompatible or by channeling their urges in directions of less disruptive or bothersome responses. Patients utilizing these techniques are encouraged to suppress the unwanted responses for longer and longer intervals. On the medication side of the board, the highly knowledgeable medical professionals with whom we collaborate regularly are willing to augment SSRI medications with alpha-2 agonists or with typical and atypical neuroleptics with greater confidence, even when the practice seems to cross the boundaries of standard diagnostic prescription. They are methodical and judicious in their approach to the addition of other medications, particularly stimulants because of their potential to initiate or exacerbate tics in some cases.

We have used ERP for years with our patients, even those who were primarily identified as T/TS patients, and have observed what recent research has begun to confirm: that this approach doesn’t necessarily result in the rebound effect that would be expected when response suppression tactics are applied to apparent tics and that the repetitive responses often respond favorably to these techniques. By applying a broader range of therapeutic techniques to our TOCD patients we have had increasing success in helping these individuals achieve greater degrees of mastery over their symptoms. I recommend that other clinicians adopt the TOCD perspective in efforts to help such patients.

Helping Patients and Families Make Sense of the “Alphabet Soup Syndrome”

Communication regarding the nature of their problems to patients and their families is a crucial, early step in therapeutic practice. Many of our patients come to us because OCD has been detected among a complex of other diagnoses. I have come to refer to the perplexing array of diagnoses that are so often affixed to the children who enter our offices as the “Alphabet Soup Syndrome.” Tics or TS may or may not be in the diagnostic mix, but

among the commonly co-diagnosed conditions are: attention deficit disorder (ADD), learning disabilities (LDs), oppositional defiant disorder (ODD), often at least one diagnosis designed to explain the child’s emotional “meltdowns” (depression or mood disorder are typical), and recently, the unofficial diagnosis of sensory processing disorder (SPD). These children and their parents want to know how they developed so many things wrong with them. Often, by the time I see them the child and parents are “doctored out,” bewildered, and far from convinced that they are yet on the right therapeutic path. Questions about the appropriate diagnoses, the proper therapeutic approach(es) and the role of medication are foremost in their minds.

A large proportion of these patients (certainly not all – there are other routes to Alphabet Soup) have hallmark features of TOCD along with the array of associated conditions that occur so often in conjunction with a nervous system that is prone to developing tics, but which may not manifest the kind of simple tics that are easiest to identify. Previous visits to mental health professionals typically fostered the view that the child suffered from a seemingly unrelated cluster of disorders. At our clinic we view the situation differently; we see it as an array of problems resulting from a developing nervous system from which clinical features emerge that cut across a range of diagnostic categories. The “tourette nervous system” is “hair triggered, easily aroused and hard to settle.” This suggests that excitatory mechanisms within their nervous systems, those which initiate and energize actions and feelings generally function well; but that complementary inhibitory mechanisms that modulate these functions are not up to the task. This asynchrony can certainly present challenges for parents, teachers, family members and peers. The particular mix of features makes it difficult for the child to adapt to the requirements that society establishes for children, for example, to “sit still in class, pay attention to the teacher, and learn the material,” “wait your turn,” or “put away your toys and come to the table.”

Since conceptually TOCD is linked with a “tourette nervous system” (but not necessarily with tics per se), the array of “disorders” can be viewed as the cluster of associated conditions common to T/TS. As in cases of “TS Plus” there is likely to be improvement in many of the neurological symptoms through maturation alone. The developing nervous system achieves greater harmony and balance as characterized by the diminution or disappearance of tics in most sufferers by adulthood. The idea that time may very well be “on our side” can be comforting to the individual and family who feel battered by the problems

My Personal Story*

Still Struggling With Obsessive Compulsive Disorder

By Robin Queen Watts

My name is Robin, and I have had Obsessive-Compulsive Disorder (OCD) for twenty-five years. At first I had no idea what was happening to me. I worked every day and went to college several nights until ten o'clock. This did not stop the rituals I had to perform nightly. I was copying everything off of all the kitchen appliance labels or various other labels then. I started tearing off any label to help lessen the compulsion. There would be no peace of mind for me until every ritual was completed each night. Also, no books or magazines could be left out where I could view them. If so, I had to carry them downstairs to my comfort zone. There would be no peace of mind for me until every ritual was completed each night. I felt I was losing my mind. How could anyone understand what was happening to me? I was ashamed and feared that if I told anyone, they would say that I was crazy.

One day I had the television on the *Sally Jesse Raphael Show*. People were talking about what was happening to me. Suddenly I realized I was not alone, and others had the monster too. I felt relieved to know that I was not alone.

OCD can strike at any age. Young, old, rich or poor: it is an equal opportunity disease. You may have to count turning lights on and off until your quota is complete. You may have to lock and unlock a door a certain number of times. Repeatedly checking to see if you turned the faucets off does not make any sense either, but you may have to do it. Saying foul words until you reach your quota can be gut wrenching. When it starts, the monster has you under its control. Where did it come from? How do you learn to live with it? Is there any way you can get rid of it? Those are questions I would love the answers to.

OCD affects many people every day. All have certain rituals that they must do. I had to count turning the lights on and off a certain number of times each night. If I tried to do it earlier in the day that would not satisfy the monster. I had to copy things from the various labels or remove them. I could not tolerate books or magazines left where I could see them. This disorder is ruthless. No matter how hard you try to quit, you must finally give in. It will not let you rest until you do. This disorder has no compassion. The agony it puts you through every day denies you the opportunity

for any normalcy in life.

When my problems began it was about the books and magazines left where I could see them. Then I had to copy the labels or remove them. Turning lights on and off soon followed. It would not stop; it just kept growing. It was like some evil beast that I wished would just stop and leave me alone. I felt like I was alone. I felt ashamed, and I thought I was going crazy. I kept asking why I was being punished. What did I do to deserve this monster that cannot be stopped or controlled?

At times even now the terror scares me and the deep dark hole starts to drag me down. Right now I cannot leave the house until late afternoon. Seeing the movie *As Good as It Gets*, in which Jack Nicholson plays a lonely writer with OCD, was like watching my life from the outside. I tell very few people about it. You do not know how people will react. They may laugh or tell you that you are crazy.

It is hard to find a person who you can trust with what you may tell them. For years my mother was the person I confided in to share all my fears and anxieties. When she died, so many of my problems returned with a vengeance. The terrible fear that makes your heart flutter and your skin sweat, the feeling that you are all alone in the world, the fear that some will not believe you all came back as strong as ever. The problem with darkness is the feeling of being the only one awake while your part of the world sleeps.

My mother worked with me for years to comfort me and try as she could to understand what was happening to me. I finally got to where I could tell her anything. I will never tell another soul even part of the thoughts I shared with her, for they were our secret talks. She took the time to listen as no one else ever will, and that really helped. She saw what was happening to me and comforted me by listening; it was the only thing she could do to combat the monster. She is in Heaven now and not having strokes. I thank God for she is at peace and able to enjoy her new body and home.

In addition, a great psychiatrist helped me and prescribed medication that made the demands less severe. Unfortunately, he has retired now, and so I lost my other confidant. My husband does the best he can.

Currently, my life has very little happiness anymore. I do not care about doing things with others. I lead a sad life. I really do not care about life because my mother is no longer here to help me keep control of the monster. I spend most of my time alone and it suits me fine. I have become a shut-in, and I stay away from the outside world because .

I feel like I have no one left to confide in since my mother died. I have told my husband so much, but this only gives me peace of mind for a short time. If you have someone to talk to, do not be afraid to ask them to just listen.

I wrote this with the hope that I could help others in some small way. I know I will make it, but there are still some things I will always have to cope with. There are many of us that share the OCD monster. I have walked many miles in these shoes, and I feel I truly have experienced the worst the monster has to offer. But I can only hope that a total cure will become available in my lifetime.

*** My Personal Story is a new feature of the OCD Newsletter. If you have a story to tell, write it and send it to info@ocfoundation.org. Other people with OCD want to hear what you have to say.**

**To Reach the
OCF's Goal of
Effective
Treatment for
Everyone,
Please Contribute
to the OCF's
Research Fund**

Message From the President

(continued from page 2)

the right therapist. There will be volunteers and a receptionist who will be trained by the best...Patricia Perkins, one of the Founders of the Obsessive Compulsive



Foundation and the former Executive Director of the OCF. Even though Patti will not be based in Boston, she will be only a phone call away.

Many of our programs, in spite of the move, are still going strong.

Co-Chairs of the OCF Annual Conference, Diane Davey (OCF Board Member) and Denise Egan Stack (President of the Boston Affiliate and current Affiliate Representative to the National Board), are working on the Annual Conference that will be held in Boston from August 1 – August 3, 2008. In addition to the many consumer sessions offered each year, the 2008 conference will offer a Professional Clinical Track, a Professional Scientific Track and a poster session. CME's will be available.

Dr. Sabine Wilhelm, a member of the OCF Scientific Advisory Board (SAB), is chairing the OCF Grant Review Committee. Her colleagues are reviewing the recently submitted research proposals for 2008 and will announce the award recipients later this



spring. Another member of the SAB, Dr. Alec Pollard, is currently planning the next Behavioral Therapy Institute (BTI). The exact date and location are yet to be determined. Please visit our website for further information pertaining to the next BTI.

Elaine Davis, a Western Pennsylvania Affiliate Alternate Representative to the OCF Board of Directors, is chairing the newly formed Board Committee, Information Technology. Elaine and her committee are reviewing the Website and suggesting changes that will allow for increased member participation and downloading of infor-



mation. Elaine has also volunteered to answer emails that have been coming into the office during this period of transition.

Thank you to everyone who has stepped forward to help the Obsessive Compulsive Foundation in this period of transition.

Best Regards,

Joy Kant

President, OCF Board of Directors



Yale Researchers

(continued from page 1)

agents might be helpful in the treatment of OCD. Over the subsequent years, physicians at the Yale OCD Research Clinic have continued to treat individuals suffering from OCD with riluzole augmentation and results from an additional 13 patients treated with riluzole over a 6-12 month period will be published in the coming months.

These new results, which have been accepted for publication in the Journal of Clinical Psychopharmacology, further suggest that riluzole augmentation may prove to be useful in some patients with OCD. In the upcoming 2008 publication, we have outlined our finding, i.e., 6 out of the 13 patients treated with open label riluzole augmentation improved over a six to twelve week period of treatment; a seventh improved with a longer duration of treatment. Additionally, the authors will report their long term observations of those subjects who continued treatment with riluzole for over a year. These long term results, albeit in a small sample size, demonstrate that improvements seen with riluzole persist over time.

Again, it is important not to over-interpret results from medication trials that do not include a placebo control group; there are plenty of examples in psychiatry of medications that looked promising in open-label trials but then were not supported by careful placebo-controlled trials. A more scientifically rigorous, double-blind placebo controlled trial is underway at Yale with plans for the study to potentially expand to other sites.

In addition to the work studying riluzole in treatment resistant OCD, the Yale Clinic is also exploring other novel pharmacotherapeutic treatments, pharmacogenetic studies and neurophysiological experiments to enhance our clinical understanding of OCD.

If you are interested in being in one of these trials, the Yale OCD Research Clinic provides a comprehensive psychiatric and medical evaluation free of charge for prospective outpatients or inpatients with symptoms of OCD and related disorders. Participation in the clinic's research trials is typically offered on both an inpatient and outpatient basis. Individuals who are willing to travel from other states to participate in a study may be offered the opportunity to stay on the inpatient unit for ease of study participation (the inpatient stay is also free of charge for those participating in the research). For more information about the research or clinical consultations at the Yale OCD Research Clinic, contact the clinic nurse coordinator, Suzanne Wasyluk, RNC, at 203-974-7523. Principal researchers Vlad Coric, M.D. and Christopher Pittenger, M.D., Ph.D. (clinic director) are also available to answer questions via email at: vladimir.coric@yale.edu or christopher.pittenger@yale.edu.

How We Treat BDD*

Treatments for Body Dysmorphic Disorder

By Jennifer L. Greenberg, Psy.M. and Sabine Wilhelm, Ph.D.

Massachusetts General Hospital and Harvard Medical School

Many people dislike some aspects of their appearance; however, some individuals are so distressed about the way they look that it interferes with their daily life. This condition, known as body dysmorphic disorder (BDD), is characterized by a preoccupation with an imagined or slight flaw in appearance. Any area of the body can be the focus of the concern, but it most commonly involves the face or head (e.g., skin, hair, or nose). BDD is a relatively commonly occurring disorder with significant psychological impact, and though BDD has been described in the literature for more than a century, it remains an under-recognized disorder.

BDD usually begins in childhood or adolescence and affects about 0.7% to 3% of the population. When prevalence is examined in dermatology and plastic surgery settings, these rates are even higher, suggesting that individuals with BDD do not often seek psychological help. Rather, individuals, including adolescents, often shop around for doctors hoping to fix the flaw cosmetically. These individuals are most likely to seek treatment from dermatologists, plastic surgeons, or dentists because of the urge to fix the perceived flaw or because they are too ashamed and embarrassed to seek help from mental health professionals. However, those who pursue costly surgical, dermatologic and other medical treatments are typically left feeling the same or worse than before the procedure. If left untreated BDD symptoms typically persist for years.

Individuals with BDD experience significant distress about their perceived flaw and are often plagued by unwanted thoughts or images about the flaw for several hours a day. More than 90% of individuals with BDD perform repetitive, compulsive behaviors such as frequent mirror checking, excessive grooming (e.g., hair combing or shaving), comparing with others, reassurance seeking, skin picking, and camouflaging (e.g., with a hat, makeup, or clothes) in an effort to alleviate their distress; however, these actions produce only short-term relief. Some individuals with BDD fully believe that others take special notice of the perceived defect and talk about it or

mock it. Individuals who are completely convinced about the existence of the defect and are unable to consider that the flaw might exist only in their imagination are thought to have a delusional variant of the disorder.

For most individuals with BDD, a fear of being evaluated negatively by others, difficulty concentrating, and poor self-esteem make it difficult to keep up with daily life. Consequently, everyday functioning and quality of life are compromised. Individuals may avoid daily activities, including dating and other social activities, school and work. In extreme cases individuals can become housebound or attempt suicide. Of those who do seek psychiatric or psychological help, it is often for the depression and anxiety associated with their BDD. When compared to individuals with depression, the general U.S. population, and individuals with recent heart disease, those with BDD tend to report a poorer quality of life. People with BDD are also at increased risk for psychiatric hospitalization, suicidal ideation, suicide attempts, and completed suicide. Suicide risk factors, including high rates of psychiatric hospitalization, being single or divorced, psychiatric comorbidity (including anxiety, depression, and impulsive aggression), poor social supports, and poor self-esteem, have all been associated with BDD.

Although data from children and adolescents are limited, symptoms appear generally similar to those in adults in that they are extremely upsetting, time-consuming, and commonly involve the face or head. However, children and adolescents with BDD are less likely to identify their concerns as existing in their imagination. In other words, kids with BDD tend to be more convinced that they are "ugly, disfigured, monstrous," and that others are judging them based on these flaws. When compared to individuals who develop BDD in adulthood, those with child/adolescent-onset BDD are at greater risk for developing additional disorders (e.g., substance abuse, social phobia, depression); this may be due in part to its interference with social and academic functioning during a critical developmental period.

Unfortunately, during adolescence, when symptoms typically emerge, BDD may be overlooked or mistaken for normal adolescent concerns about appearance. One way

to distinguish normative concerns from BDD is to observe the time-consuming and distressing nature of the appearance concerns. For example, if appearance-related thoughts or behaviors are consuming more than one hour per day and are resulting in significant distress, tardiness to school or social events, difficulty concentrating, withdrawal from friends, family or school, or drop in grades, further evaluation may be warranted.

Although many individuals with BDD obtain multiple, costly surgical, dermatologic, and other cosmetic procedures, the outcome is usually poor. These treatments rarely improve BDD symptoms. More commonly, individuals report an increase in appearance concerns (e.g., feeling "disfigured") or new areas of preoccupation (e.g., from a concern with nose size to hair texture) following cosmetic (medical or non-medical) procedures. In severe cases, patients upset with the results of their procedures have committed suicide, threatened harm against or acted violently toward the treating physician, or murdered the physician.

Over the past decade some promising psychological and pharmacological treatments have emerged to help those with BDD. Most medication studies have examined serotonin reuptake inhibitors (SRIs) while psychological treatments have focused primarily on behavior therapy or cognitive behavioral therapy. Treatments for BDD aim to reduce compulsive behaviors and the distress associated with appearance concerns and to improve quality of life and overall functioning.

Although patients with BDD may receive various psychotropic medications, including antidepressants (e.g., tricyclic antidepressants, monoamine oxidase inhibitors, and neuroleptics, evidence for the effectiveness of non-SRI antidepressants or neuroleptics in treating BDD symptoms has not been adequately demonstrated. SRIs (e.g., clomipramine) and selective SRIs (SSRIs; e.g., fluoxetine, fluvoxamine, citalopram) are the first-line medication treatment for BDD. SRIs have been found to be more effective than non-SRI antidepressants or sugar pill placebos. Interestingly, patients with delusional BDD tend to respond as favorably as those with the nondelusional variant to SRI treatment. Of note, relatively high SRI doses over a longer period are

rphic Disorder

indicated than for SRI use in depression.

Preliminary findings from clinical case reports suggest that SRIs may also be effective in children and adolescents. The first multi-site, controlled trial of SRIs for the treatment of pediatric BDD is currently underway (Mount Sinai School of Medicine, NY, NY; Butler Hospital, Providence, RI; Massachusetts General Hospital, Boston, MA). The potential effectiveness of SRIs in this population is promising given its similarities to adult BDD and pediatric OCD; SRIs are already indicated for the treatment of pediatric and adult OCD.

A useful psychological procedure that can be applied is cognitive-behavioral therapy (CBT), which is a present-focused, short-term, goal-directed approach. It has been shown to be helpful in treating BDD symptoms in both individual and group formats. Currently, there is no empirical basis for any other psychological treatment in the treatment of BDD, and some reports suggest insight-oriented psychotherapy alone is not effective in reducing BDD symptoms. In CBT, the therapist and patient work as a team to identify and challenge current thought and behavior patterns maintaining the BDD symptoms. Specifically, CBT involves gradual exposure to anxiety-provoking situations. Avoidance behaviors (e.g., avoiding eye contact) and rituals performed to decrease the anxiety or distress associated with the situation (e.g., comparing self to others in the room) are eliminated. The patient is asked to repeat the exposure until the accompanying anxiety or discomfort decreases (i.e., habituation). In addition, distorted or unhelpful appearance-related thoughts are identified and modified to more accurate, adaptive beliefs.

Individuals with BDD place an excessive value on sociocultural ideals of physical attractiveness in determining their sense of self. In addition, they tend to underestimate their own physical attractiveness and overestimate others' attractiveness. BDD patients also tend to focus exclusively on the area(s) of concern when determining their body image and self-esteem. In other words, they pay attention only to the aspects of their appearance with which they are dissatisfied. This type of selective attention and over-importance of appearance (overvalued ideation) are thought to contribute to the maintenance of BDD

symptoms. Selectively attending to their flaw generally leads to increased feelings of distress and makes the individual with BDD more likely to engage in compulsive or avoidant behavior to reduce his/her distress. This phenomenon is consistent with neuropsychological findings that found patients with BDD over-focus on the small details in lieu of seeing the big picture. Similar patterns have been observed among individuals with OCD. Mirror retraining is another CBT strategy that has been used to help challenge inaccurate beliefs and perceptions and help patients see the big picture.

CBT strategies are practiced in session and over the week as assignments between sessions in order to facilitate mastery of new skills in multiple environments. Family members may be involved in some capacity. For example, when a patient with BDD comes in for treatment, it is not uncommon for parents or significant others to be involved in rituals (e.g., by providing reassurance about appearance). This is understandable as it difficult to watch a loved one suffer. However, CBT can be useful in providing information about the disorder and in instructing family members in more adaptive, supportive strategies. In summary, CBT for adults with BDD is effective in improving BDD symptoms and has also been shown to improve related symptoms, such as depressive symptoms, insight, body image, self-esteem and social anxiety.

Whereas both medication and psychological treatment studies have obtained promising results, additional clinical and research attention should focus on developing more effective treatment strategies for BDD. In addition, given its early onset and chronic, devastating course, early identification and treatment of the disorder are crucial. Appearance concerns associated with BDD are more than a matter of vanity. The serious psychological impact on individuals with BDD and their loved ones calls for increased public and professional awareness of the disorder and the development of more effective interventions.

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(phone: 617-726-6766, toll free: 888-HEAL-BDD, email: bdd@partners.org, website: www.massgeneral.org/bdd/), which offers several free treatment studies for cognitive behavior therapy as well as pharmacotherapy for BDD and related disorders.

Other BDD programs that offer free treatment options include the Body Image Program at Butler Hospital in Providence, RI (phone: 401-455-6466, email: bdd@butler.org, website: www.BodyImageProgram.com) and the BDD Program at Mount Sinai School of Medicine in NY, NY (phone: 212-369-5123, email: holly.bamilton@mssm.edu, website: www.mssm.edu/psychiatry/ciadp/ciadp_bdd.shtml).

Recommended Readings

For a comprehensive source on BDD and its treatment readers are directed to *The Broken Mirror: Understanding and Treating Body Dysmorphic Disorder** by Katharine Phillips (Oxford University Press, 2005). *Feeling Good about the Way You Look: A Program for Overcoming Body Image Problems** by Sabine Wilhelm (The Guilford Press, 2006) will help individuals understand their body image concerns and decide whether they should be evaluated for BDD. It offers a CBT-based self-help approach with step-by-step guidelines for overcoming appearance-related thoughts and behaviors.

**These books are available through the OCF Bookstore.*

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OCD and Tourette Syndrome

(continued from page 13)

that led them to therapy. The therapeutic endeavor becomes a group effort with the greater goal of keeping the child out of trouble and on track toward a hopeful future.

Language used to describe the clinical conditions matters too. Children can feel like “damaged goods” when told that they have neurological disorders. They respond in notably positive ways, however, when described as “extra alive,” with “supercharged” nervous systems, “brimming over with energy that is almost impossible to contain – spilling out in bursts of behavior, emotions and spontaneity.” A metaphor can make a world of difference! They drive a Ferrari through life, while most others drive a Toyota. The engine may be cranky, the handling may be skittish and quirky, and driven carelessly it is an accident or speeding ticket waiting to happen. But when you know how to handle it, it is the most impressive vehicle on the road. (If that seems too macho, then instead it can be the image of a skittish and often hard-to-control thoroughbred race horse among a herd of “old nellies.”) Little chests puff out with pride, and parents see their child in a new light.

That still leaves a significant challenge given the often formidable array of problems that must be addressed in important spheres of the child’s life and the uncooperative nature of the nervous system underlying those problems. In targeting which among the problems must be confronted most aggressively, battles must be chosen wisely. It is useful for the therapist to remain humble in setting goals for treatment, resisting bold plans to “fix the kid” in all regards. Patience and acceptance of imperfections by others may be therapeutically beneficial, more realistic and, therefore, more effective in the long run.

But with proper education and support from significant individuals (parents, siblings, other family members, teachers, friends, coaches, etc.) and with orchestrated individual, family and (whenever possible) school interventions drawn from empirically-supported cognitive-behavioral principles, there is an excellent chance to help the child stay on course. A positive perspective is invaluable; since, in many cases, the course of treatment can be rough. It helps to point out that while the course of treatment can be very challenging, children like these can have wonderful potential. Many lively, energetic, funny, creative, fun-loving, exuberant, innovative, empathic, tireless, passionate, curious, feisty, formidable, relentless adults

arose from these shaky foundations. With energies channeled in the right direction, these naturally energetic, “extra alive” nervous systems can supercharge a formidable young adult.

Understanding and Short-Circuiting a Developmental Form of OCD

Over the years of dealing with children who inhabit the TOCD and alphabet soup world, I have had innumerable opportunities to observe kids at every possible stage of experiencing and coping with OCD, T/TS and TOCD in all their manifestations, combinations and permutations. Among the “Eureka” moments was the realization that the underpinning of a “tourettic nervous system” can, with the passage of time, evolve into a classic adult form of OCD, sometimes with reverberations of the tourettic features but often without a trace of their origins. How might this happen? Let me outline the steps:

Phase 1: A child is born with a “tourettic nervous system.”

Phase 2: Associated secondary clinical features emerge; simple tics emerge (optional).

Phase 3: TOCD features (compulsions/complex tics) emerge.

Phase 4: Cognitive elaborations are attached to complex tics/compulsions.

Phase 5: Classic (cognitive/affective) OCD develops, tourettic features diminish or disappear (but may persist in some individuals). In this scenario, foundations for a tourettic-developmental form of OCD are set when a child is born with “tourettic nervous system:” quick to excite, slow to quiet, irritable, highly arousable, with inhibitory mechanism developmentally not up to the task of effectively keeping impulses in check. (Note: It is possible that these nervous system characteristics may be acquired through mechanisms such as “PANDAS” – Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infection). While tics may emerge in some, many children will exhibit various combinations of behavioral/psychological characteristics associated with the “tourettic nervous system” (attention problems, impulsivity, explosiveness, sensory processing problems, etc.) without any discernable tics. Tourettic OCD features emerge and generate behavioral “demands” on the individual (in concerns with symmetry, “just right” or “just so” requirements, evening up, ordering, touching, etc.) driven by localized physical tension, generalized somatic discomfort, and diffuse psychological distress (but not obsessions and anxiety as in classic forms of OCD). In time, however, primitive cognitive attributions become associated with these recurrent efforts to end distress (or something bad might happen”). The cognitive “overlays” can

become more specific and further elaborated upon to evolve into classic OCD concerns such as: “Harm will come to my parents,” “God will be angry at me” or “I may get sick.” Since these are anxiety-provoking ideas, a classic cognitive-affective OCD emerges out of the tourettic raw materials and continues to coexist with the sensory-motor components or to outlast these elements as the nervous system matures and tourettic features disappear. The classic OCD features are then the familiar, chronic, debilitating OCD that does not characteristically abate or disappear with passage into adulthood. One very important implication may be drawn: successful early intervention with TOCD sufferers can short-circuit the formation of classic OCD with its potential to be to be a life-long affliction.

Conclusion: Conceptual Integration of TS and OCD

The ideas and perspectives presented here, while derived from extensive clinical experience, much reflection and deductive reasoning, range from somewhat to highly speculative. Time will tell which and how many of these ideas will receive the empirical validation necessary for widespread acceptance by the clinical and scientific communities. At this early stage of efforts to comprehend the relationship between OCD and TS and to develop effective treatments for these disorders, the conceptual viewpoints presented here do have potential advantages. First, they describe interactions between two frequently comorbid and curiously related conditions. Second, they describe the functional relationships between subjective experiences common to individuals in these clinical groups and the problematic repetitive behavior patterns that they exhibit. Third, they provide for a wider range of treatment options for effectively addressing a challenging clinical subgroup. Fourth, they point to a potential mechanism in which OCD etiology is traced to tourettic origins. Fifth, they provide for conceptual unification of seemingly disparate, but commonly co-existing, clinical phenomena.

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