Obsessive Compulsive Disorder

A CASE HISTORY
Bob saw his psychiatrist for treatment of depression for six months before he finally had the courage to bring up his other 'secret' problem. Since childhood he had a compulsion to count things. He had to count the letters in words and in people's names. If the letters added up to any number except 9 he felt a sense of release and could stop counting. He knew it was silly but nevertheless he had a fear that if he did not do this something bad could happen to his mom or dad. He seemed unable to stop doing this. He did poorly in school because he was distracted by his secret compulsion to count letters when he should have been paying attention to the teacher's lessons. He was later bothered as a teenager by upsetting sacrilegious mental images when he was in church. Having these sacrilegious images made him feel that he lost his soul for eternity.

In addition to these two problems, he was having trouble driving. When he felt a bump as his tire rolled over a little stone, he would think he may had accidentally run over a pedestrian. He would instantly check his rearview mirror for the injured person he feared was lying on the road. Relieved to not see an injured person, he would start to drive forward. Obsessing that the injured person might have been flung entirely off the road by the impact, he would then stop, and back up his car to the scene, and search the ditch and weeds. These obsessions and compulsions were taking over his life but he was too embarrassed to tell anyone about them, even his psychiatrist, up till now.

His psychiatrist explained that this was caused by OCD, a metabolic-physiological abnormality, and was treatable with one of about six special medications that work on a chemical in the brain called serotonin. After the medication began to work, they would employ special psychological maneuvers to help overcome this problem.

The psychiatrist told him that with the combined treatment an average person can expect improvement in 3 months. This knowledge filled him with hope for a better future.

- A woman visits her dermatologist, complaining of extremely dry skin and seldom feeling clean. She showers for two hours every day.
- A lawyer insists on making coffee several times each day. His colleagues do not realize that he lives in fear that the coffee will be poisoned, and he feels compelled to pour most of it down the drain. The lawyer is so obsessed with these thoughts that he spends 12 hours a day at work -- four of them worrying about contaminated coffee.
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- A man cannot bear to throw anything away. Junk mail, old newspapers, empty milk cartons all "could contain something valuable that might be useful someday." If he throws things away, "something terrible will happen." He hoards so much clutter that he can no longer walk through his house. Insisting that nothing be thrown away, he moves to another house where he continues to hoard.
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- I know I am going through something right now, but I came to a realization tonight.... Sitting in the corner of my room some months ago, weeping from the amount of pain my obsessions were giving me. The doubt that I had schizophrenia, the doubt that I might hurt someone, or that I was paranoid. People go about their daily lives, never having to face their most deep horrible fears. Sometimes they will, and it will be bad for them, but they get over it and might not have to face it again.... We live each day facing our biggest fears. Not just every day, but every minute of everyday. If I told the strongest man on earth to live with their deepest core driven fear, they would not want to, or would they be able to handle it. We do. I wake up and face fears, I go to sleep and face fears, I leave the house and face fears, and then I put the other worries of life on top of that. No, no one told me it would be a picnic, I wasn't expecting a lifetime of unbridled love and hedonism, but I did not think I would be facing intense fears each day. WE DO.... and that is what makes us stronger, more courageous, more brilliant, and more in tune with what we know we are capable of than any other person on this planet. I am optimistic that we will not be dealing with this forever, but if we had to we would prevail. I just want to tell everyone that when it gets hard, it gets hard. By no matter what means we will always stay on top, and if you make it out of this life with just having to survive OCD, than you are lucky. We all need a support group, but there is one inside all of us, or hearts, our will to thrive, our courage, and no matter how hard the waves are crashing against us, we will always stay afloat. When I look at myself in a corner weeping some months ago, I don't see a meek boy terrified of life. I see a strong person fighting to win in life.

These people suffer obsessive-compulsive disorder (OCD). The National Institute of Mental Health estimates that more than 2 percent of the U.S. population, or nearly one out of every 40 people, will suffer from OCD at some point in their lives. The disorder is two to three times more common than schizophrenia and bipolar disorder.

I Try to Remember

1. Everybody Doesn't Have to Love me
   Not everybody has to love me or even like me. I don't necessarily like everybody I know, so why should everybody else like me? I enjoy being liked and being loved, but if somebody doesn't like me, I will still be okay and still feel like I am an okay person. I cannot make somebody like me, any more than someone can get me to like them. I don't need approval all the time. If someone does not approve of me, I will still be okay.

2. It is Okay to Make Mistakes
   Making mistakes is something we all do, and I am still fine and worthwhile person when I make them. There is no reason for me to get upset when I make a mistake. I am trying, and if I make a mistake, I am going to continue trying. I can handle making a mistake. It is okay for others to make mistakes, too. I will accept mistakes in myself and also mistakes that others make.

3. Other People Are Okay and I am Okay
   People who do things I don't like are not necessarily bad people. They should not necessarily be punished just because I don't like what they do or did. There is no reason why other people should be the way I want them to be, and there is no reason why I should be the way somebody else wants me to be, and I will be whatever I want to be. I cannot control other people or change them. They are who they are; we all deserve basic respect.

4. I don't Have to Control Things
   I will survive if things are different than what I want them to be. I can accept things the way they are, accept people the way they are, and accept myself the way I am. There is no reason to get upset if I can't change things to fit my idea of how they ought to be. There is no reason why I should have to like everything. Even if I don't like it, I can live with it.

5. I Am Responsible for My Day
   I am responsible for how I feel and what I do. Nobody can make me feel anything. If I have a rotten day, I am the one who allowed it to be that way. If I have a great day I am the one who deserves credit for being positive. It is not the responsibility of other people to change so that I can feel better. I am the one who is in charge of my life.

6. I can Handle It When Things Go Wrong
   I don't need to watch out for things to go wrong. Things usually go just fine, and when they don't, I can handle it. I don't have to waste my energy worrying. The sky won't fall in; things will be okay.

7. It is Important to Try
   I can. Even though I may be faced with difficult tasks, it is better to try than to avoid them. Avoiding a task does not give me any opportunities for success or joy, but trying does. Things worth having are worth the effort. I might not be able to do everything, but I can do something.

8. I Am Capable
   I don't need someone else to take care of my problems. I am capable. I can take care of myself. I can make decisions for myself. I can think for myself. I don't have to depend on somebody else to take care of me.

9. I Can Change
   I don't have to be a certain way because of what has happened in the past. Every day is a new day. It's silly to think I can't help being the way I am. Of course I can. I can change.

10. Other People Are Capable
    I can't solve other people's problems for them. I don't have to take on other people's problems as if they were my own. I don't need to change other people or fix up their lives. They are capable and can take care of themselves, and can solve their own problems. I can care and be of some help, but I can't do everything for them.

11. I Can Be Flexible
    There is more than one way to do something. More than one person has had good ideas that will work. There is no one and only "best" way. Everybody has ideas that are worthwhile. Some may make more sense to me than others, but everyone's ideas are worthwhile, and everyone has something worthwhile to contribute.

Author Unknown

What is Obsessive-compulsive disorder?
Obsessions are intrusive, irrational thoughts -- unwanted ideas or impulses that repeatedly well up in a person's mind. Again and again, the person experiences disturbing thoughts, such as "My hands must be contaminated; I must wash them"; "I may have left the gas stove on"; "I am going to injure my child." On one level, the sufferer knows these obsessive thoughts are irrational. But on another level, he or she fears these thoughts might be true. Trying to avoid such thoughts creates great anxiety.

Compulsions are repetitive rituals such as hand washing, counting, checking, hoarding, or arranging. An individual repeats these actions, perhaps feeling momentary relief, but without feeling satisfaction or a sense of completion. People with OCD feel they must perform these compulsive rituals or something bad will happen.

Most people at one time or another experience obsessive thoughts or compulsive behaviors. Obsessive-compulsive disorder occurs when an individual experiences obsessions and compulsions for more than an hour each day, in a way that interferes with his or her life.

OCD is often described as "a disease of doubt." Sufferers experience "pathological doubt" because they are unable to distinguish between what is possible, what is probable, and what is unlikely to happen.

Who gets OCD?
People from all walks of life can get OCD. It strikes people of all social and ethnic groups and both males and females. Symptoms typically begin during the teenage years or young adulthood.

What causes OCD?
A large body of scientific evidence suggests that OCD results from a chemical imbalance in the brain. For years, mental health professionals incorrectly assumed OCD resulted from bad parenting or personality defects. This theory has been disproven over the last 20 years. OCD symptoms are not relieved by psychoanalysis or other forms of "talk therapy," but there is evidence that behavior therapy can be effective, alone or in combination with medication. People with OCD can often say why they have obsessive thoughts or why they behave compulsively. But the thoughts and the behavior continue. Scientists have also observed that people with OCD have increased metabolism in the basal ganglia and the frontal lobes of the brain. This, scientists believe, causes repetitive movements, rigid thinking, and lack of spontaneity. People with OCD often have high levels of the hormone vasopressin. People whose brains are injured sometimes develop OCD, which suggests it is a physical condition. If a placebo is given to people who are depressed or who experience panic attacks, 40 percent will say they feel better. If a placebo is given to people who experience obsessive-compulsive disorder, only about two percent say they feel better. This also suggests a physical condition.

Clinical researchers have implicated certain brain regions in OCD. They have discovered a strong link between OCD and a brain chemical called serotonin. Serotonin is a neurotransmitter that helps nerve cells communicate.

How do people with OCD typically react to their disorder?
People with OCD generally attempt to hide their problem rather than seek help. Often they are remarkably successful in concealing their obsessive-compulsive symptoms from friends and co-workers. An unfortunate consequence of this secrecy is that people with OCD generally do not receive professional help until years after the onset of their disease. By that time, the obsessive-compulsive rituals may be deeply ingrained and very difficult to change.

How long does OCD last?
OCD will not go away by itself, so it is important to seek treatment. Although symptoms may become less severe from time to time, OCD is a chronic disease. Fortunately, effective treatments are available that make life with OCD much easier to manage.

Is age a factor in OCD?
OCD usually starts at an early age, often before adolescence. It may be mistaken at first for autism, pervasive developmental disorder, or Tourette's syndrome, a disorder that may include obsessive doubting and compulsive touching as symptoms. Like depression, OCD tends to get worse as the person grows older, if left untreated. Scientists hope, however, that when the OCD is treated while the person is still young, the symptoms will not get worse with time.

What are other examples of behaviors typical of people who suffer from OCD? People who do the following may have OCD:

- repeatedly check things, perhaps dozens of times, before feeling secure enough to go to sleep or leave the house. Is the stove off? Is the door locked? Is the alarm set?
- fear they will harm others. Example: A man's car hits a pothole on a city street and he fears it was actually a body.
- feel dirty and contaminated. Example: A woman is fearful of touching her baby because she might contaminate the child.
- constantly arrange and order things. Example: A child can't go to sleep unless he lines up all his shoes correctly.
- are excessively concerned with body imperfections -- insist on numerous plastic surgeries, or spend many, many hours a day body-building.
- are ruled by numbers, believing that certain numbers represent good and others represent evil.
- are excessively concerned with sin or blasphemy.

Anxiety about thoughts or rituals over which you feel you have little control is typical of OCD. OCD can take so many different forms. Let's try to make sense of it.

Obsessions are thoughts, often intrusive and upsetting.

Obsessions are to be distinguished from ruminations or worries about routine life issues such as finances, children or job security. Some examples of obsessions in OCD may be thoughts or mental images of an upsetting nature like violence, vulgarities, harm to self or harm to others. Obsessions may be of special numbers, colors, or single words or phrases . . . sometimes even melodies.

Here are some examples.
Obsessions with:
GERMS
DIRT
DOUBT
ORDER
SYMMETRY
REPUGNANT SEXUAL THOUGHTS
REPUGNANT RELIGIOUS THOUGHTS
REPUGNANT IMAGES
HORRIFIC IMAGES
VIOLENT IMAGES
FEAR OF FORGETTING
FEAR THAT A MISTAKE WILL HARM A LOVED ONE

Compulsions are behaviors.
A compulsion is a repetitive behavior in response to an urge. It is difficult to stop this behavior. Obsessions provoke compulsions. Examples include washing the hands too many times, showering too frequently or washing things about the home like clothes or floors or even groceries.

How much is too much?
Many experts agree that engaging in more than an hour a day raises suspicions of OCD. Compulsions are often performed repetitively and in some stereotyped or ritualistic fashion. You may be bothered by urges to perform rituals like repeatedly turning off and on a light switch until it 'feels right'.

Here are some examples.
Compulsions to repeatedly:
WASH HANDS
SHOWER
CHECK LOCKS
CHECK STOVES
TOUCH THINGS
COUNT ITEMS
ORDER THINGS
CLEAN THINGS
PERFORM SILLY RITUALS UNTIL IT 'FEELS' RIGHT.

The list of all possible obsessions and compulsions is long and varied. Fortunately OCD seems to bother each person with OCD in only a few particular ways. We do not know why OCD bothers each person in a different way. It does seem that it is almost as if OCD 'knows' what would bother you the most and hones in on that. For example, if you are a particularly religious person you might be plagued by repugnant religious OCD thoughts that are a lot more upsetting to you than they would be to a person with below average concern about religion.

Often the obsession comes first and the compulsion seems to be a response to the obsession. For example, a person may have an obsessive fear of ingesting or absorbing illegal drugs from indirect contact with people they suspect to be taking illegal drugs. Such a person may obsessively fear losing his mind from using a restaurant's public rest room after seeing someone they suspect may be a drug addict using the facility. After leaving the restaurant, he may have to throw away his shoes and floor mats in his car that may have been 'contaminated'. He may have to scrub his hands in bleach exactly ten times perfectly. Other articles of clothing may have to be washed repeatedly or thrown away. He may be afraid to take medicine that has been touched by a pharmacist who he thinks might be using marijuana after hours, fearing that some of the residue might have contaminated their medicine.

There is no pleasure in carrying out these rituals. There is only temporary relief from the anxiety caused by the obsession. Obsessive Compulisive Disorder (OCD) is a medical brain disorder that causes problems in information processing. It is not caused by a "weak" or unstable personality.

Before the arrival of modern medications and cognitive behavior therapy, OCD was generally thought to be untreatable. Most people with OCD continued to suffer, despite years of ineffective psychotherapy. Today, luckily, treatment can help most people with OCD. Although OCD is usually completely curable only in some individuals, most people achieve meaningful and long-term symptom relief with comprehensive treatment.

Superstitious, worries, doubts and beliefs all are common in everyday life. However, when they become so excessive such as hours of hand washing or make no sense at all such as driving around and around the block to check that an accident didn't occur then a diagnosis of OCD is made. In OCD, it is as though the brain gets stuck on a particular thought or urge and just can't let go. People with OCD often say the symptoms feel like a case of mental hiccups that won't go away.

Symptoms of OCD
OCD usually involves having both obsessions and compulsions, though a person with OCD may sometimes have only one or the other.

Typical OCD Symptoms	
Common Obsessions:	Common Compulsions:
Contamination fears of germs, dirt, etc.	Washing
Imagining having harmed self or others	Repeating
Imagining losing control of aggressive urges	Checking
Intrusive sexual thoughts or urges	Touching
Excessive religious or moral doubt	Counting
Forbidden thoughts	Ordering/arranging
A need to have things "just so"	Hoarding or saving
A need to tell, ask, confess	Praying

OCD symptoms can occur in people of all ages. Not all Obsessive-Compulsive behaviors represent an illness. Some rituals (e.g., bedtime songs, religious practices) are a welcome part of daily life. Normal worries, such as contamination fears, may increase during times of stress, such as when someone in the family is sick or dying. Only when symptoms persist, make no sense, cause much distress, or interfere with functioning do they need clinical attention.

Obsessions
Obsessions are thoughts, images, or impulses that occur over and over again and feel out of your control. The person does not want to have these ideas, finds them disturbing and intrusive, and usually recognizes that they don't really make sense. People with OCD may worry excessively about dirt and germs and be obsessed with the idea that they are contaminated or may contaminate others. Or they may have obsessive fears of having inadvertently harmed someone else (perhaps while pulling the car out of the driveway), even though they usually know this is not realistic. Obsessions are accompanied by uncomfortable feelings, such as fear, disgust, doubt, or a sensation that things have to be done in a way that is "just so."

Compulsions
People with OCD typically try to make their obsessions go away by performing compulsions. Compulsions are acts the person performs over and over again, often according to certain "rules." People with an obsession about contamination may wash constantly to the point that their hands become raw and inflamed. A person may repeatedly check that she has turned off the stove or iron because of an obsessive fear of burning the house down. She may have to count certain objects over and over because of an obsession about losing them. Unlike compulsive drinking or gambling, OCD compulsions do not give the person pleasure. Rather, the rituals are performed to obtain relief from the discomfort caused by the obsessions. Other features of Obsessive-Compulsive Disorder

OCD symptoms cause distress, take up a lot of time (more than an hour a day), or significantly interfere with the person's work, social life, or relationships.

Most individuals with OCD recognize at some point that their obsessions are coming from within their own minds and are not just excessive worries about real problems, and that the compulsions they perform are excessive or unreasonable. When someone with OCD does not recognize that their beliefs and actions are unreasonable, this is called OCD with poor insight. OCD symptoms tend to wax and wane over time. Some may be little more than background noise; others may produce extremely severe distress.

When does Obsessive-Compulsive Disorder begin?
OCD can start at any time from preschool age to adulthood (usually by age 40).
One third to one half of adults with OCD report that it started during childhood. Unfortunately, OCD often goes unrecognized. On average, people with OCD see three to four doctors and spend over 9 years seeking treatment before they receive a correct diagnosis. Studies have also found that it takes an average of 17 years from the time OCD begins for people to obtain appropriate treatment.

OCD tends to be under-diagnosed and under-treated for a number of reasons. People with OCD may be secretive about their symptoms or lack insight about their illness. Many healthcare providers are not familiar with the symptoms or are not trained in providing the appropriate treatments. Some people may not have access to treatment resources. This is unfortunate since earlier diagnosis and proper treatment, including finding the right medications, can help people avoid the suffering associated with OCD and lessen the risk of developing other problems, such as depression or marital and work problems. **Is Obsessive-Compulsive Disorder Inherited?**
No specific genes for OCD have yet been identified, but research suggests that genes do play a role in the development of the disorder in some cases. Childhood-onset OCD tends to run in families (sometimes in association with tic disorders). When a parent has OCD, there is a slightly increased risk that a child will develop OCD, although the risk is still low. When OCD runs in families, it is the general nature of OCD that seems to be inherited, not specific symptoms. Thus a child may have checking rituals, while his mother washes compulsively.

What causes Obsessive-Compulsive Disorder?
There is no single, proven cause of OCD. Research suggests that OCD involves problems in communication between the front part of the brain (the orbital cortex) and deeper structures (the basal ganglia). These brain structures use the chemical messenger serotonin. It is believed that insufficient levels of serotonin are prominently involved in OCD. Drugs that increase the brain concentration of serotonin often help improve OCD symptoms.

Pictures of the brain at work also show that the brain circuits involved in OCD return toward normal in those who improve after taking a serotonin medication or receiving cognitive-behavioral psychotherapy.

Although it seems clear that reduced levels of serotonin play a role in OCD, there is no laboratory test for OCD. Rather, the diagnosis is made based on an assessment of the person's symptoms. When OCD starts suddenly in childhood in association with strep throat, an autoimmune mechanism may be involved, and treatment with an antibiotic may prove helpful.

What other problems are sometimes confused with OCD?
Some disorders that closely resemble OCD and may respond to some of the same treatments are Trichotillomania (compulsive hair pulling), body dysmorphic disorder (imagined ugliness), and habit disorders, such as nail biting or skin picking. While they share superficial similarities, impulse control problems, such as substance abuse, pathological gambling, or compulsive sexual activity, are probably not related to OCD in any substantial way.

The most common conditions that resemble OCD are the tic disorders (Tourette's disorder and other motor and vocal tic disorders). Tics are involuntary motor behaviors (such as facial grimacing) or vocal behaviors (such as snorting) that often occur in response to a feeling of discomfort. More complex tics, like touching or tapping tics, may closely resemble compulsions. Tics and OCD occur together much more often when the OCD or tics begin during childhood.

Depression and OCD often occur together in adults, and, less commonly, in children and adolescents. However, unless depression is also present, people with OCD are not generally sad or lacking in pleasure, and people who are depressed but do not have OCD rarely have the kinds of intrusive thoughts that are characteristic of OCD.

Although stress can make OCD worse, most people with OCD report that the symptoms can come and go on their own. OCD is easy to distinguish from a condition called posttraumatic stress disorder, because OCD is not caused by a terrible event. Schizophrenia, delusional disorders, and other psychotic conditions are usually easy to distinguish from OCD. Unlike psychotic individuals, people with OCD continue to have a clear idea of what is real and what is not.

In children and adolescents, OCD may worsen or cause disruptive behaviors, exaggerate a pre-existing learning disorder, cause problems with attention and concentration, or interfere with learning at school. In many children with OCD, these disruptive behaviors are related to the OCD and will go away when the OCD is successfully treated.

Individuals with OCD may have substance-abuse problems, sometimes as a result of attempts to self-medicate. Specific treatment for the substance abuse is usually also needed.

Children and adults with pervasive developmental disorders (autism, Asperger's Disorder) are extremely rigid and compulsive, with stereotyped behaviors that somewhat resemble very severe OCD. However, those with pervasive developmental disorders have extremely severe problems relating to and communicating with other people, which do not occur in OCD.

Only a small number of those with OCD have the collection of personality traits called Obsessive Compulsive Personality Disorder (OCPD). Despite its similar name, OCPD does not involve obsessions and compulsions, but rather is a personality pattern that involves a preoccupation with rules, schedules, and lists; perfectionism; an excessive devotion to work; rigidity; and inflexibility. However, when people have both OCPD and OCD, the successful treatment of the OCD often causes a favorable change in the person's personality.

What is Trichotillomania?
Trichotillomania is a term coined by a French dermatologist in 1889 to describe the compulsive or irresistible urge he saw in patients to pluck out their hair. The word trichotillomania is derived from the Greek thrix, hair; tillein, to pull; and mania, madness or frenzy. This name is somewhat of a misnomer in that people with trichotillomania are not "mad", "psychotic" or "crazy" as the name suggests. In psychiatry, trichotillomania is classified as an impulse control disorder as are conditions such as compulsive gambling, kleptomania (compulsive stealing) and pyromania (compulsive fire setting).

Impulse control disorders are characterized by the inability to control or resist the temptation (or impulse) to do something harmful to oneself or someone else. A sufferer sometimes experiences a sense of increasing tension

before performing the behavior and can feel a sense of relief or release of tension afterwards. Sometimes people even express a degree of pleasure after having performed the act.

Features of trichotillomania that fit the description of an impulse control disorder include the inability to resist urges to pull out one's hair, mounting tension before pulling and feeling of relief afterward.

DSM-IV Definition
More formally, the fourth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) defines trichotillomania as:

- Recurrent pulling out of one's hair resulting in noticeable hair loss.
- An increasing sense of tension immediately before pulling out the hair or when attempting to resist the behavior.
- Pleasure, gratification, or relief when pulling out the hair.
- The disturbance is not better accounted for by another mental disorder and is not due to a general medical condition (e.g., a dermatological condition).
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Not all patients who pull out their hair meet these strict criteria. Nonetheless, they frequently have a distressing problem that might very well benefit from treatment.

Where do TTM sufferers pull their hair from?	
Scalp	75%
Eyelashes	53%
Eyebrows	42%
Pubic area	17%
Beard/face	10%
Mustache	7%
Arm	10%
Leg	7%
Chest	3%
Abdomen	2%

Source: Christenson, Gary, M.D.; American Journal of Psychiatry 148:3 March 1991

What is OCD?		What is not OCD.	
Adult	**Children/Adolescents**	**Adult**	**Children/Adolescents**
A man who washes his hands 100 times a day until they are red and raw.	A 14-year-old boy who is late for school every day because he can't get out of the shower until he has lathered and rinsed exactly 41 times.	A woman who unfailingly washes her hands before every meal.	A 16-year-old girl who spends 20 minutes washing and styling her hair every day before school.
A woman who locks and relocks her door before going to work every day-for half an hour.	A child who checks over and over that the light switch is in the off position, even though it is obvious that the light is off.	A woman who double-checks that her apartment door and windows are locked each night before she goes to bed.	A child who double-checks that the light is off as she leaves a room, just like her parents have asked her to do.

A man who stores 19 years of newspapers "just in case"--with no system for filing or retrieving.	A child who collects used matches as protection against his house burning down.	A woman who dedicates all her spare time and money to building her art collection.	A child whose bedroom wall is covered with pennants of all his favorite sports teams.
A college student who must tap on the door frame of every classroom 14 times before entering.	A seven-year- old girl who can't stop skipping over cracks in the sidewalk until she has done it 99 times because she fears that something horrible will happen to her mother if she doesn't.	A musician who practices a difficult passage over and over again until it's perfect.	A five-year-old girl who laughs with her friends while skipping over cracks in the sidewalk reciting, "Step on a crack, break your mother's back."
A woman who spends hours alphabetizing every item in her kitchen cabinets and who must have all clothing organized by color.	A fifth-grade boy who cannot leave the gym locker-room until the laces on his sneakers are tied with loops that are exactly the same size.	An office manager who won't leave the office until his desk is clear and his in-box empty.	A 17-year-old boy who enjoys arranging groceries on store shelves as his first part-time job.

Some useful Questions in determining if your client has OCD:

If you lose more than an hour a day to any of the below, and if the need for such repetitive behavior causes marked distress or significantly interferes with your normal routines, relationships or occupational or social functioning, OCD should be considered as a diagnosis (with further investigation).

- Does performing a certain ritual feel like an urgent necessity of life?
- Do recurrent intrusive thoughts cause discomfort or anxiety?
- Does an extreme need for order and cleanliness force you to tidy things/bathe/shower/wash your hands excessively?
- Do you do things (e.g. checking locks) over and over?
- Do you repeatedly perform certain routines to prevent "bad things" from happening?
- Do you have great difficulty discarding things even when they have no practical value?

People with OCD describing their life.

---My favorite description of OCD is sane people doing insane stuff. With me, it was erasing. That's right. Erasing. It started when I started college. You know, college is supposed to be, like, the greatest time of your life? For me, it was the worst. My usual perfectionism just got totally out of control when it came to writing papers and essays. Good was not good enough for me. I'd erase sentences over and over until I'd erase a hole in the paper, and have to start all over again. The act of erasing became a compulsion I had no control over. I'd no sooner start to write something than I'd start erasing it. I'd try so hard to stop. But I couldn't.

My friends thought this was hilarious at first. But then they got worried. So did my girlfriend. She knew about OCD because someone in her family has it. She wanted me to go to a doctor for help. I told her any doctor would think I was crazy if I showed up with a story about not being able to stop erasing. She said I was wrong, that they heard this kind of stuff all the time, that now, doctors treat behavior like mine all the time. "Oh, right," I said, "like there are millions of people out there who can't stop erasing!" She looked at me, and you know what she said? She said, "Get a new attitude or get a new girlfriend."

That's when I went for help. The doctor told me that repetitious behavior is not the worst aspect of OCD. He said, "That dubious distinction goes to low self-esteem, and that's what we don't want to happen to you." - Anonymous

-------I don't remember a time when I didn't have OCD. I mean, I was always kind of fanatical about everything being perfect. Like many OCD sufferers, my symptoms really started escalating during adolescence. I was ridiculously fastidious about my wardrobe and appearance, but then lots of teenagers are.

Then came marriage and motherhood. Somehow, they pushed my OCD into the danger zone. My house not only had to be clean, it had to be sanitized. At all times. Everything in it, including my three children, had to be decontaminated on a regular basis. Shoes had to be left outside the front door. Baths had to be taken before bedrooms could be entered. Bedrooms, like all rooms in the house, had to be spotlessly sanitary. Wrinkles were out of the question. Linens had to be changed, laundered, and ironed, over and over and over. You can imagine how much time and energy were consumed in order to maintain these unrealistic standards. It not only took a terrible toll on me, but on my whole family. Imagine having a mother who files your play clothes as if they were official documents.

I felt I had to do these good things to prevent bad things from happening. When I finally sought help for my behavior, I learned this good things vs bad things logic is common with OCD. And that OCD itself is a lot more common than most people realize. I can't tell you how comforting it was just to learn that. ----Anonymous

HOW IS OCD TREATED?
The first step in treating OCD is educating the patient and family about OCD and its treatment as a medical illness. During the last 20 years, two effective treatments for OCD have been developed: cognitive-behavioral psychotherapy (CBT) and medication with a serotonin reuptake inhibitor (SRI).

Stages Of Treatment

- Acute treatment phase: Treatment is aimed at ending the current episode of OCD.
- Maintenance treatment: Treatment is aimed at preventing future episodes of OCD. Components Of Treatment
- Education: This is crucial in helping patients and families learn how best to manage OCD and prevent its complications.
- Psychotherapy: Cognitive-behavioral psychotherapy (CBT) is the key element of treatment for most patients with OCD.
- Medication: Medication with a serotonin reuptake inhibitor is helpful for many patients.

OCD can be succesfully treated with behavior therapy in the form of Exposure and Response Management. This treatment is based on the fact that prolonged, direct contact with a fearful stimulus is necessary if anxiety is to diminish.
Outline of UCLA's Structured Outpatient Program at:
Daily two hour sessions, Monday through Friday provides a treatment option that is more aggressive and intense than regular outpatient treatment. The Program lasts for 3 weeks (15 sessions) and provides state of the art behavior therapy management. On admission to the OCD Structured Outpatient Program, each participant is assigned a behavior therapist with whom they will work daily on a one-on- one basis. The first few days in the program is spent in going through detailed and specific assessment of the participant's OCD; this involves questionnaires, interviews and self monitoring of the OCD.

Based on this information, both participant and behavior therapist can establish a personalized program of behavior therapy. In the Structured Outpatient Program, an individualized behavior therapy regimen is incorporated into a program of education and support. Participants will also take part in OCD specific therapeutic groups, and also be expected to do assignments on their own.

Education and support of the family or involved loved ones is an integral part of the program. Often, those people living with some one who has OCD have questions and concerns about how to best help. The program will provide support and information on how to cope with a loved one who has OCD.

EDUCATING YOUR CLIENTS
Is There Anything I Can Do To Help My Disorder?
Absolutely yes. You need to become an expert on your illness.
Since OCD can come and go many times during your life, you and your family or others close to you need to learn all about OCD and its treatment. This will help you get the best treatment and keep the illness under control. Read books, attend lectures, talk to your doctor or therapist, and consider joining the Obsessive-Compulsive Foundation. A list of recommended readings and information resources is given at the end of this handout. Being an informed patient is the surest path to success.

How Often Should I Talk With My Clinician?
When beginning treatment, most people talk to their clinician at least once a week to develop a CBT treatment plan and to monitor symptoms, medication doses, and side effects. As you get better, you see your clinician less often. Once you are well, you might see your clinician only once a year.

Regardless of scheduled appointments or blood tests, call your clinician if you have:

- Recurrent, severe OCD symptoms that come out of nowhere
- Worsening OCD symptoms that don't respond to strategies you learned in CBT
- Changes in medication side effects
- New symptoms of another disorder (e.g., panic or depression)
- A crisis (e.g., a job change) that might worsen your OCD

What Should I Do If I Feel Like Quitting Treatment?
It is normal to have occasional doubts and discomfort with your treatment. Discuss your concerns and any discomforts with your doctor, therapist, and family. If you feel a medication is not working or is causing unpleasant side effects, tell your doctor. Don't stop or adjust your medication on your own. You and your doctor can work together to find the best and most comfortable medicine for you. Also, don't be shy about asking for a second opinion from another clinician, especially about the wisdom of cognitive-behavior therapy.

Consultations with an expert on medication or behavioral psychotherapy can be a great help. Remember it is harder to get OCD under control than to keep it there, so don't risk a relapse by stopping your treatment without first talking to your clinician.

What Can Families And Friends Do To Help?
Many family members feel frustrated and confused by the symptoms of OCD. They don't know how to help their loved one. If you are a family member or friend of someone with OCD, your first and most important task is to learn as much as you can about the disorder, its causes, and its treatment. At the same time, you must be sure the person with OCD has access to information about the disorder.

Helping the person to understand that there are treatments that can help is a big step toward getting the person into treatment. When a person with OCD denies that there is a problem or refuses to go for treatment, this can be very difficult for family members. Continue to offer educational materials to the person. In some cases. it may help to hold a family meeting to discuss the problem, in a similar manner to what is often done when someone with alcohol problems is in denial. Family problems don't cause OCD, but the way families react to the symptoms can affect the disorder, just as the symptoms can cause a great deal of disruption and many problems for the family. OCD rituals can tangle up family members unmercifully, and it is sometimes necessary for the family to go through therapy with the patient. The therapist can help family members learn how to become gradually disentangled from the rituals in small steps and with the patient's agreement. Abruptly stopping your participation in OCD rituals without the patient's consent is rarely helpful since you and the patient will not know how to manage the distress that results. Your refusal to participate will not help with those symptoms that are hidden and, most important, will not help the patient learn a lifelong strategy for coping with OCD symptoms.

Negative comments or criticism from family members often make OCD worse, while a calm, supportive family can help improve the outcome of treatment. If the person views your help as interference, remember it is the illness talking. Try to be as kind and patient as possible since this is the best way to help get rid of the OCD symptoms. Telling someone with OCD to simply stop their compulsive behaviors usually doesn't help and can make the person feel worse, since he or she is not able to comply. Instead, praise any successful at tempts to resist OCD, while focusing your attention on positive elements in the person's life. You must avoid expecting too much or too little. Don't push too hard. Remember that nobody hates OCD more than the person who has the disorder.

Treat people normally once they have recovered, but be alert for telltale signs of relapse. If the illness is starting to come back, you may notice it before the person does. Point out the early symptoms in a caring manner and suggest a discussion with the doctor. Learn to tell the difference between a bad day and OCD, however. It is important not to attribute everything that goes poorly to OCD.

Family members can help the clinicians treat the patient. When your family member is in treatment, talk with the clinician if possible. You could offer to visit the clinician with the person to share your observations about how the treatment is going. Encourage the patient to stick with medications and/or CBT. However, if the patient has been on a certain treatment for a fairly long time with little improvement in symptoms or has troubling side effects, encourage the person to ask the doctor about other treatments or about getting a second opinion.

When children or adolescents have OCD, it is important for parents to work with schools and teachers to be sure that they understand the disorder. Just as with any child with an illness, patients still need to set consistent limits and let the child or adolescent know what is expected of him or her.

Take advantage of the help available from support groups. Sharing your worries and experiences with others who have gone through the same things can be a big help. Support groups are a good way to feel less alone and to learn new strategies for coping and helping the person with OCD.

Be sure to make time for yourself and your own life. If you are helping to care for someone with severe OCD at home, try to take turns checking in on the person so that no one family member or friend bears too much of the burden. It is important to continue to lead your own life and not let your self become a prisoner of your loved one's rituals. You will then be better able to provide support for your loved one.

PSYCHOTHERAPY
Cognitive behavioral psychotherapy (CBT) is the psychotherapeutic treatment of choice for children, adolescents, and adults with OCD. In CBT, there is a logically consistent and compelling relationship between the disorder, the treatment, and the desired outcome. CBT helps the patient internalize a strategy for resisting OCD that will be of lifelong benefit.

What Is CBT?
The BT in CBT stands for behavior therapy. Behavior therapy helps people learn to change their thoughts and feelings by first changing their behavior. Behavior therapy for OCD involves exposure and response prevention (E/RP).

Exposure is based on the fact that anxiety usually goes down after long enough contact with something feared. Thus people with obsessions about germs are told to stay in contact with "germy" objects (e.g., handling money) until their anxiety is extinguished. The person's anxiety tends to decrease after repeated exposure until he no longer fears the contact.

For exposure to be of the most help, it needs to be combined with response or ritual prevention (RP). In RP, the person's rituals or avoidance behaviors are blocked. For example, those with excessive worries about germs must not only stay in contact with "germy things," but must also refrain from ritualized washing.

Exposure is generally more helpful in decreasing anxiety and obsessions, while response prevention is more helpful in de creasing compulsive behaviors. Despite years of struggling with OCD symptoms, many people have surprisingly little difficulty tolerating E/RP once they get started.

Cognitive therapy (CT) is the other component in CBT. CT is often added to E/RP to help reduce the catastrophic thinking and exaggerated sense of responsibility often seen in those with OCD. For example, a teenager with OCD may believe that his failure to remind his mother to wear a seat belt will cause her to die that day in a car accident. CT can help him challenge the faulty assumptions in this obsession.

Armed with this proof, he will be better able to engage in E/RP, for example, by not calling her at work to make sure she arrive safely.

Other techniques, such as thought stopping and distraction (suppressing or "switching off" OCD symptoms), satiation (prolonged listening to an obsession usually using a closed-loop audiotape), habit reversal (replacing an OCD ritual with a similar but non-OCD behavior), and contingency management (using rewards and costs as incentives for ritual prevention) may sometimes be helpful but are generally less effective than standard CBT.

Traditional psychotherapy, aimed at helping the patient develop insight into his or her problem, is generally not helpful for OCD. However, a specific behavior therapy approach called "exposure and response prevention" is effective for many people with OCD. In this approach, the patient deliberately and voluntarily confronts the feared object or idea, either directly or by imagination. At the same time the patient is strongly encouraged to refrain from ritualizing, with support and structure provided by the therapist, and possibly by others whom the patient recruits for assistance. For example, a compulsive hand washer may be encouraged to touch an object believed to be contaminated, and then urged to avoid washing for several hours until the anxiety provoked has greatly decreased. Treatment then proceeds on a step-by-step basis, guided by the patient's ability to tolerate the anxiety and control the rituals. As treatment progresses, most patients gradually experience less anxiety from the obsessive thoughts and are able to resist the compulsive urges.

Studies of behavior therapy for OCD have found it to be a successful treatment for the majority of patients who complete it. For the treatment to be successful, it is important that the therapist be fully trained to provide this specific form of therapy. It is also helpful for the patient to be highly motivated and have a positive, determined attitude.

The positive effects of behavior therapy endure once treatment has ended. A recent compilation of outcome studies indicated that, of more than 300 OCD patients who were treated by exposure and response prevention, an average of 76 percent still showed clinically significant relief from 3 months to 6 years after treatment (Foa & Kozak, 1996).

Another study has found that incorporating relapse-prevention components in the treatment program, including follow-up sessions after the intensive therapy, contributes to the maintenance of improvement (Hiss, Foa, and Kozak, 1994).

One study provides new evidence that cognitive-behavioral therapy may also prove effective for OCD. This variant of behavior therapy emphasizes changing the OCD sufferer's beliefs and thinking patterns. Additional studies are required

before the promise of cognitive-behavioral therapy can be adequately evaluated. The ongoing search for causes, together with research on treatment, promises to yield even more hope for people with OCD and their families.

People react differently to psychotherapy, just as they do to medicine. CBT is relatively free of side effects, but all patients will have some anxiety during treatment. CBT can be used in individual therapy , group therapy, or family therapy. A physician may provide both CBT and medication, or a psychologist or social worker may provide CBT, while a physician manages your medications. Regardless of their specialties, those treating you should be knowledgeable about the treatment of OCD and willing to cooperate in providing your care.

How to get your client to get the most out of psychotherapy:
Keep their appointments.
Be honest and open.
Do the homework assigned to them as part of their therapy.
Give their therapist feedback on how the treatment is working.

Commonly Asked Questions About CBT
How successful is CBT? While as many as 25% of patients refuse CBT, those who complete CBT report a 50%-80% reduction in OCD symptoms after 12-20 sessions. Just as important, people with OCD who respond to CBT usually stay well, often for years to come. When someone is being treated with medication, using CBT with the medication may help prevent relapse when the medication is stopped.

How long does CBT take to work? When administered on a weekly basis, CBT may take 2 months or more to show its full effects. Intensive CBT, which involves 2-3 hours of therapist-assisted E/RP daily for 3 weeks, is the fastest treatment available for OCD.

What is the best setting for CBT? Most patients do well with gradual weekly CBT, in which they practice in the office with the therapist once a week and then do daily E/RP homework. Homework is necessary because the situations or objects that trigger OCD are unique to the individual's environment and often cannot be reproduced in the therapist's office. In intensive CBT, the therapist may come to the patient's home or workplace to conduct E/RP sessions. On occasion, the therapist may also do this in gradual CBT. In very rare cases, when OCD is particularly severe, CBT is best conducted in a hospital setting.

What Medications Are Used To Treat Obsessive-Compulsive Disorder?
Research clearly shows that the serotonin reuptake inhibitors (SRIs) are uniquely effective treatments for OCD. These medications increase the concentration of serotonin, a chemical messenger in the brain. Five SRIs are currently available by prescription in the United States:

- Clomipramine (Anafranil, manufactured by Ciba-Geigy)
- Fluoxetine (Prozac, manufactured by Lilly)
- Fluvoxamine (Luvox, manufactured by Solvay)
- Paroxetine (Paxil, manufactured by Smith-Kline Beecham)
- Sertraline (Zoloft, manufactured by Pfizer)
- Citalopram (Celexa, marketed by Forest Laboratories, Inc.)

Fluoxetine, fluvoxamine, paroxetine, citalopram, and sertraline are called selective serotonin reuptake inhibitors (SSRIs) because they primarily affect only serotonin. Clomipramine is a nonselective SRI, which means that it affects many other neurotransmitters besides serotonin. This means that clomipramine has a more complicated set of side effects than the SSRIs. For this reason, the SSRIs are usually tried first since they are usually easier for people to tolerate.

How Well Do Medications Work?
When patients are asked about how well they are doing compared to before starting treatment, they report marked to moderate improvement after 8-10 weeks on a serotonin reuptake inhibitor (SRIs). Unfortunately, fewer than 20% of those treated with medication alone end up with no OCD symptoms. This is why medication is often combined with CBT to get more complete and lasting results. About 20% don't experience much improvement with the first SRI and need to try another SRI.

Which Medication Should I Choose First?
Studies show that all the SRIs are about equally effective. However, to reduce the chance of side effects, most experts recommend beginning treatment with one of the selective serotonin reuptake inhibitors. If your client or someone in their family did well or poorly with a medication in the past, this may influence the choice. If they have medical problems (e.g., an irritable stomach, problems sleeping) or are taking another medication, these factors may cause their doctor to recommend one or another medication to minimize side effects or to avoid possible drug interactions.

What If The First Medication Doesn't Work?
First, it is important to remember that these medications don't work right away. Most patients notice some benefit after 3 to 4 weeks, while maximum benefit should occur after 10 to 12 weeks of treatment at an adequate dose of medication. When it is clear that a medication is not working well enough, most experts recommend switching to another SRI. While most patients do equally well on any of the SRIs, some will do better on one than another, so it is important to keep trying until your client finds the medication and dosage schedule that is right for them.

What Are The Side Effects Of These Medications?
In general, the SRIs are well tolerated by most people with OCD. The four SSRIs (fluoxetine, fluvoxamine, paroxetine, and sertraline) have similar side effects. These include nervousness, insomnia, restlessness, nausea, and diarrhea. The most common side effects of clomipramine are dry mouth, sedation, dizziness, and weight gain. While all five drugs can cause sexual problems, on average these are a bit more common with clomipramine. Clomipramine is also more likely to cause problems with blood pressure and irregular heart beats, so that children and adolescents and patients with preexisting heart disease who are treated with clomipramine must have electrocardiograms before beginning treatment and at regular intervals during treatment.

Remember that all side effects depend on the dose of medication and on how long you have been taking it. If side effects are a big issue, it is important to start with a low dose and increase the dose slowly. More severe side effects are associated with larger doses and a rapid increase in the dose.

Tolerance to side effects may be more likely to develop with the SSRIs than with clomipramine, so that many patients are better able to tolerate the SSRIs than clomipramine over the long term. All SRIs except fluoxetine should be tapered and stopped slowly because of the possibility of the return of symptoms and withdrawal reactions.

Some people have different side effects than others and one person's side effect (for example, unpleasant sleepiness) may actually help another person (someone with insomnia). The side effects you may get from medication depend on:

- The type and amount of medicine you take
- Your body chemistry
- Your age
- Other medicines you are taking
- Other medical conditions you have

If side effects are a problem for you, your doctor can try a number of things to help:
Reducing the amount of medicine: The doctor may gradually lower the dose to try to achieve a dose low enough to reduce side effects but not low enough to cause a relapse.

Adding another medication may be helpful for some side effects, such as trouble sleeping or sexual problems. Trying a different medicine to see if there are fewer or less bothersome side effects: Even when a medication is clearly helping, side effects sometimes make it intolerable. In such a case, trying another SRI is a reasonable strategy. Remember: Changing medicine is a complicated, potentially risky decision. Tell your clients not to stop their medicine or change the dose on their own. Discuss any medication problems they are having with their doctor.

Many experts believe that CBT is the most helpful treatment to add when someone with OCD is not responding well to medication alone. When people continue to avoid the things that make them anxious or continue to do rituals, this blocks the effects of the medication. For the medication to work, therefore, the person with OCD must try to resist doing rituals. Adding CBT to medication is helpful because it teaches those with OCD to expose themselves to the triggers that make them anxious and then to resist performing rituals.

It may also be helpful to add one of the following types of medications to an SRI:

- Low dose clomipramine to an SSRI
- An anxiety-reducing medication, such as clonazepam or alprazolam, in patients with high levels of anxiety
- A high potency neuroleptic, such as haloperidol or risperidone, when tics or thought disorder symptoms are present.

These complex medication strategies are best reserved for those who have not done well with a combination of SRI and CBT.

What If Nothing Seems To Work?
Before deciding that a treatment has failed, you need to be sure that the treatment has been given in a large enough dose for a sufficient period of time. There is little consensus among the OCD experts on what to do next when someone with

OCD fails to respond to expert CBT plus well-delivered, sequential SRI trials. Switching from an SSRI to clomipramine may improve the chances that a previously non-responsive patient may have a good response. Most experts recommend considering a trial of clomipramine after 2 or 3 failed SSRI trials.

Occasionally, a doctor may wish to combine an SSRI with clomipramine either to reduce side effects or to increase the potential benefits of medication. In the adult with extremely severe and unremitting OCD, neurosurgical treatment to interrupt specific brain circuits that are malfunctioning can be very helpful.

In patients who have severe OCD and depressions electroconvulsive therapy (ECT) may be of benefit.

Many, if not most, people seem to prefer combination treatment.

The need for medication depends on the severity of the OCD and the age of the person. In milder OCD, CBT alone is often the initial choice, but medication may also be needed if CBT is not effective enough. Individuals with severe OCD or complicating conditions that may interfere with CBT (e.g., panic disorder, depression) often need to start with medication, adding CBT once the medicine has provided some relief. In younger patients, clinicians are more likely to use CBT alone. However, trained cognitive-behavioral psychotherapists are in short supply. Thus, when CBT is not available, medication may become the treatment of choice. Consequently, it is likely that many more people with OCD receive medication than CBT. Before deciding on a treatment approach, you and your client will need to assess their OCD symptoms, other disorders that they might have, the availability of CBT, and their wishes and desires about what treatment they want.

Alternative treatment
Because OCD sometimes responds to SSRI antidepressants, a botanical medicine called St. John's Worth (Hypericum perforatum) might have some beneficial effect as well, according to herbalists. Known popularly as "Nature's Prozac," St. John's Wort is prescribed by herbalists for the treatment of anxiety and depression. They believe that this herb affects brain levels of serotonin in the same way that SSRI antidepressants do. Herbalists recommend a dose of 300 mg., three times per day. In about 1 out of 400 people, St. John's Wort (like Prozac) may initially increase the level of anxiety. Homeopathic constitutional therapy can help rebalance the patient's mental, emotional, and physical well being, allowing the behaviors of OCD to abate over time.

Managed Care Networks
More and more people in the United States are receiving their medical care in some kind of managed care setting (HMO, preferred provider organizations etc.). If your client has OCD, it is important that they talk to their case manager or administrator to find out what types of therapy are available in their network.

Many managed care programs are instituting group therapy programs as a means of providing appropriate treatment at an affordable cost.

Should I take anti-obsessional medications only when I am feeling stressed?
No. This is a common mistake. These medications are meant to be taken on a regular daily basis to maintain a constant level in your blood stream. They are not taken like the typical anti-anxiety agents, when you feel upset or anxious. It is best not to miss dosages if possible. Having said this, it is unlikely that any adverse effect on OCD will occur if a daily dose is missed occasionally, and sometimes missed dosages are prescribed by your doctor to help manage troublesome side effects, such as sexual dysfunction (see earlier section).

What if I feel as if I've failed because I need a drug to help me?
A useful way of thinking about the use of medication for OCD is to compare your illness with a common medical disorder such as diabetes. There is growing evidence that OCD is, in fact, a neurologic or medical illness and not simply a result of some problem in the environment or of improper upbringing. As with the diabetic who needs insulin to live a normal life, some OCD patients need anti-compulsive medication to function normally (diabetics, like Obsessive-Compulsives, often feel angry and up set about having to take medication). There is no evidence that OCD is a result of anything that the patient has done, and it is best to consider it a chemical or neurologic disorder affecting a part of the brain.

What if you client is afraid to take medications because of their obsessional fears about drugs?
Usually, with reassurance from a doctor that they trust, their fears can be overcome. If they still refuse to take medication, behavior therapy can be started first, and part of the therapy can focus on their reluctance to take medication. Experience indicates that the combination of medication and behavior therapy will maximize their chances for improvement.

How much does it cost to take these drugs?
Unfortunately, these drugs are very expensive and can cost the patient up to $6 or $7 per day for larger doses. When the patent expires on each of these drugs, other companies can make generic forms of each drug, and then the prices will fall. However, this will not happen for many years with the drugs currently available.

Why are they so expensive?
One can think of all sorts of sinister reasons why pharmaceutical companies charge so much for these medications, but we must keep in mind that it costs many millions of dollars to bring just a single drug to market in the United States. Most drugs do not make it to the market and represent a lost investment. But, if the pharmaceutical companies do not try out new agents, no progress in this area is likely. These companies spend millions in research trying to identify new compounds that may have therapeutic value. Without pharmaceutical companies, there would likely be few, if any, advances in clinical pharmacology in the United States, and we would not have new drugs available to us.

Pharmaceutical companies are also heavily involved in promoting awareness of the various diseases, including OCD, for which they have a medication. These promotions (television, radio, print) benefit patients as they often are the means by which patients discover that they have OCD, that it has a name , and that it can be treated. Pharmaceutical companies have even been active in promoting non-drug treatments, such as behavior therapy, when they have nothing financially to gain. They also sponsor educational programs to physicians, and have been instrumental in spreading the knowledge base about OCD to both physicians and patients. They have been financial backers of organizations like the national Obsessive-Compulsive Foundation.

Can I get the drugs if I am poor?
Often, pharmaceutical-company representatives visit physicians and leave free samples of medications. Physicians may give these samples to patients who cannot afford the expense of the medications. In addition, each of the pharmaceutical companies involved in the production of the five primary anti-obsessional drugs offers free medication to patients who are truly quite poor. The Pharmaceutical Research and Manufacturers Association publishes a directory of indigent programs for those who cannot afford medications. Physicians can request a copy of the guide by calling (202) 835-3450. To get more information on each company's programs, you or your physician can contact the indigent-patient program at the following companies directly:

Luvox: Solvay Patient Assistance Program: (800) 788-9277

Prozac: Lilly Cares Program: (800) 545-6962

Paxil: SmithKline Paxil Access To Care Program: (800) 546-0420 (patient requests): (215) 751-5722 (physician requests)

Zoloft: Pfizer Prescription Assistance: (800) 646-4455

Anafranil: Ciba-Geigy Patient Support Program: (800) 257-3273 (908) 277-5849

Effexor: Wyeth-Ayerst Labs: (800) 568-9936 (physician requests)

Celexa: Forest Pharmaceutical Company Indigent Patient Program: (800) 678-1605 (physician requests)

How long does it take anti-obsessional medications to work?
It is important not to give up on a medication until you have been taking it at a therapeutic dose for 10 to 12 weeks. Many patients feel no positive effects for the first few weeks of treatment, but then they may improve greatly. Unfortunately during the early part of treatment, patients may only have side effects and no positive results, and sometimes physicians forget to tell patients about this lag in response. We do not know why the medications take so long to work for OCD. Keep in mind that even many psychiatrists give up on the medications after four to six weeks, since this is the time it takes for depressed patients to improve. Thus, you may have to remind your psychiatrist to keep you on the medication longer. In the large studies that have been done, each medication helps about 75% to 85% of the patients at least a little. About 50% to 60% of patients in each trial had at least a moderate response to medication. We know that some patients have no response at all. If you do not respond to the first medication, then it is important to go on to the next. There have been patients who have had no response to three of the above medications, then have a wonderful response to the next one. One patient wrote: "Seeking an effective medication for OCD is a lot like dating to find a mate; don't be afraid to shop around and try different meds till you find one that works for you!"

MAINTENANCE TREATMENT
Once OCD symptoms are eliminated or much reduced -- a goal which is practical for the majority of those with OCD then maintenance of treatment gains becomes the goal.

Maintaining Treatment Gains
When patients have completed a successful course of treatment for OCD, most experts recommend monthly follow-up visits for at least 6 months and continued treatment for at least 1 year before trying to stop medications or CBT. Relapse is very common when medication is withdrawn, particularly if the person has not had the benefit of CBT. Therefore, many experts recommend that patients continue medication if they do not have access to CBT.

Individuals who have repeated episodes of OCD may need to receive long-term or even lifelong prophylactic medication. The experts recommend such long-term treatment after 2 to 4 severe relapses or 3 to 4 milder relapses.

Discontinuing Treatment
When someone has done well with maintenance treatment and does not need long-term medication, most experts suggest discontinuing medication only very gradually, while giving CBT booster sessions to prevent relapse. Gradual medication withdrawal usually involves lowering the dose by 25% and then waiting 2 months before lowering it again, depending on how the person responds.

Because OCD is a lifetime waxing and waning condition, you should always feel comfortable returning to your clinician if your OCD symptoms come back.

SUPPORT GROUPS
Support groups are an invaluable part of treatment. These groups provide a forum for mutual acceptance, understanding, and self-discovery. Participants develop a sense of camaraderie with other attendees because they have all lived with OCD. People new to OCD can talk to others who have learned successful strategies for coping with the illness. Obsessive Compulsive Anonymous (OCA)

Is a fellowship of people who share their Experience, Strength, and Hope with each other that they may solve their common problem and help others to recover from OCD. The only requirement for membership is a desire to recover from OCD. There are no dues or fees, we are self-supporting through our own contributions.

OCA is not allied with any sect, denomination, politics, organization or institution, does not wish to engage in any controversy, neither endorses nor opposes any causes.
Our primary purpose is to recover from OCD and to help others.
We choose to remain anonymous at the public level for several good reasons. Anonymity allows us to share our personal stories, knowing that they will remain in the confidence of those who attend our meetings. Anonymity also reinforces that it is the program not the individual, that is responsible for the recovery.
We, as a fellowship , have found that together we can get well when separately we could not. Many of us have spent countless hours 'battling' our obsessions and compulsions, swearing them off forever only to find ourselves right back where we started.
There is a solution! The twelve steps, as originated by Alcoholics Anonymous, and adapted for OCA, can bring relief to our common dilemma.
Most of us have found, that using this program along with our friends in the meetings can reduce or eliminate our obsessions and compulsions.

Here Are OCA's 12 Steps
Step 1. We admitted we were powerless over our obsessions and compulsions-that our lives had become unmanageable.
Step 2. Came to believe that a power greater than ourselves could restore us to sanity.
Step 3. Made a decision to turn our will and our lives over to the care of God, as we understood him.
Step 4. Made a searching and a fearless moral inventory of ourselves.
Step 5. Admitted to God, to ourselves, and to another human being then exact nature of our wrongs.
Step 6. Were entirely ready to have God remove all these defects of character.
Step 7. Humbly asked God to remove our shortcomings.
Step 8. Made a list of all persons we had harmed, and became willing to make amends to them all.
Step 9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
Step 10. Continued to take personal inventory and when we were wrong promptly admitted it.
Step 11. Sought through prayer and meditation to improve our conscious contact with God as we understand God, praying only for knowledge of Gods will for us and the power to carry that out.
Step 12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to those who still suffer from Obsessive Compulsive Disorder, and to practice these principles in all our affairs.**

** AA's twelve Steps adapted with permission of A.A. World Service inc.

Writing
In the OCA program, writing is an individual, personal tool generally used as a means of releasing one's feelings, thoughts, concerns, ideas, etc. rather than acting out on them in unhealthy compulsive ways.

Although there are as many methods for implementing this tool as there are OCA members, some common methods include simply using paper and a writing instrument such as a pen or pencil, using a journal, or a writing book or tablet, or using a computer. There are many ways this tool could be incorporated into one's program, including the following; Written assignments, during (12) step or book studies that designate time for writing about the readings, written 10th steps, in "journaling" about personal issues, resentments, fears, etc., creating letters to a Higher Power, or writing letters not meant to be sent, to a person expressing negative emotions or resentful feelings about that person , or a situation.

Abstinence
A commitment to abstinence.....
This is a commitment a day at a time to sane & guilt-free behavior. With this commitment (of allowing oneself to sit with the uncomfortable feelings or urges) or action, we are able to find an ease in practicing the principles of step 1. Slogans

From OCA
Slogans are gentle reminders that this is a simple program for complicated people. Urging us to be easy on ourselves. Some Useful Slogans are.....

- One Day At A Time. ... First Things First.
- Easy Does It....But, Do It! ... Let It Go.
- Progress Not Perfection. ... Turn It Over.
- HALT! ...(Don't get to HUNGRY, ANGRY, LONELY or TIRED)
- Too Much Analyzing, Leads to Paralyzing.
- FEAR! (False Evidence Appearing Real). &
- FEAR! (Face Everything & Recover)
- KISS! (Keep It Simple Sweetie)... Thy Will Be Done, Not Mine!
- Identify, Don't Compare.... Don't Analyze, Utilize!
- Act As If! ... Don't Should On Yourself!
- When I'm in My Own Head, I'm in A Bad Neighborhood.!
- TAKE What you WANT! & LEAVE the REST!
- Develop an Attitude of Gratitude!
- Your Only As Sick As Your Secrets.!
- TODAY, Is The TOMORROW You Worried About YESTERDAY!
- HOW!... Honesty, Open-mindedness, Willingness.
- LET GO !,,,& LET GOD !.....Good Orderly Direction !
- Feelings Aren't, Always Facts !
- This Too, ...Shall Pass!
- Don't Give Up before The Miracle!
- Stinkin Thinkin Leads To Drinkin !...& Stinking Thinking Leads To More Stinking Thinking !
- SIN! (Self Imposed Nonsense)

JUST FOR TODAY I will try to live through this day only, and not tackle all my problems at once. I can do something for twelve hours that would appall me if I felt that I had to keep it up for a lifetime.

JUST FOR TODAY I will be happy. This assumes to be true what Abraham Lincoln said, that "Most folks are as happy as they make up their minds to be."

JUST FOR TODAY I will adjust myself to what it is, and not try to adjust everything to my own desires. I will take my "luck" as it comes, and fit myself to it.

JUST FOR TODAY I will try to strengthen my mind. I will study. I will learn something useful. I will not be a mental loafer. I will read something that requires effort, thought and concentration.

JUST FOR TODAY I will exercise my soul in three ways: I will do somebody a good turn, and not get found out: if anybody knows of it, it will not count. I will do at least two things I don't want to do- just for exercise. I will not show anyone that my feelings are hurt; they may be hurt, but today I will not show it.

JUST FOR TODAY I will be agreeable. I will look as well as I can, dress becomingly, keep my voice low, be courteous, criticize not one bit. I won't find fault with anything, nor try to improve or regulate anybody but myself.

JUST FOR TODAY I will have a program. I may not follow it exactly, but I will have it. I will save myself from two pests: hurry and indecision.

JUST FOR TODAY I will have a quiet half hour all by myself, and relax. During this half hour, sometime, I will try to get a better perspective of my life.

JUST FOR TODAY I will be unafraid. Especially I will not be afraid to enjoy what is beautiful, and to believe that as I give to the world, so the world will give to me.

What Is Life Like For Children Who Have OCD?
OCD can make daily life very difficult and stressful for children. OCD symptoms often take up a great deal of a child's time and energy, making it difficult to complete tasks such as homework or household chores in a timely manner. Children may worry that they are "crazy" because they are aware their thinking is different than that of their friends and family. A child's

self-esteem can be negatively affected because the OCD has led to embarrassment time and time again, or has made the child feel "bizarre" or "out of control."

Mornings And Evenings Can Be Especially Difficult For Children With OCD. In the morning, they often feel they must do their rituals exactly right, or the rest of the day will not go well. Meanwhile, they are feeling rushed to be on time for school. This combination leads to feeling pressured, stressed, and irritable. In the evenings, they may feel compelled to finish all of their compulsive rituals before they can go to bed. At the same time, they know they must get their homework done and take care of any household chores and responsibilities. Some children stay up late into the night because of their OCD, and are then exhausted the following day.

Children with OCD frequently don't feel well physically. This may be due to the general stress of having the disorder, or it may be related to poor nutrition or the loss of sleep. In addition, obsessions and compulsions related to food are common, and these can lead to irregular or "quirky" eating habits. Because of these and other factors, many children with OCD are prone to stress-related ailments such as headache, or an upset stomach.

Children with OCD sometimes have episodes in which they are extremely angry with their parents. This is usually because the parents have become unwilling (or are unable!) to comply with the child's OCD-related demands. For example, children with obsessions about germs may insist that they be allowed to shower for hours, or demand that their clothes be washed numerous times or a particular way. Even when parents set reasonable limits, children with OCD can become excessively anxious and angry. However, this anger does not justify physical or verbal abuse between parent and child. If violence or abuse is occurring within the home, it should not be tolerated, and seeking professional help may be necessary.

Friendships and peer relationships are often stressful for those with OCD because they typically try very hard to conceal their rituals from peers.

When the disorder is severe, this becomes impossible, and the child may get teased or ridiculed. Even when the OCD is not severe, it can affect friendships because of the amount of time spent preoccupied with obsessions and compulsions, or because friends react negatively to unusual OCD-related behaviors.

OCD and Other Psychiatric Disorders Children with OCD appear more likely to have additional psychiatric problems than those who do not have the disorder. Having two (or more) separate psychiatric diagnoses at the same time is called co morbidity. Below is a list of psychiatric conditions that frequently occur along with OCD:

- Additional anxiety disorders (such as panic disorder or social phobia)
- Depression/dysthymia
- Disruptive behavior disorders (such as oppositional defiant disorder, or attention-deficit hyperactivity disorder)
- Learning disorders
- Tic disorders/Tourette's syndrome
- Trichotillomania (hair pulling)
- Body dysmorphic disorder (imagined ugliness) Sometimes comorbid disorders can be treated with the same medication prescribed to treat the OCD. Depression, additional anxiety disorders, and trichotillomania may improve when a child takes anti-OCD medication.

On the other hand, ADHD, tic disorders, and disruptive behavior disorders usually require additional treatments, including medications that are not specific to OCD.

In general, using the smallest amount of medication effective in controlling symptoms, and starting low and going slow in regard to drug dosing are common sense approaches. In unusually complicated situations, or in situations where the OCD appears resistant to drug treatment, a consultation with an expert in the area of childhood OCD is warranted. There is little doubt that OCD often runs in families. However, it appears that genes are only partially responsible for causing the disorder. If the development of OCD were completely determined by genetics, pairs of identical twins would always both have the disorder, or both not have it.

For example, eye color is entirely determined by genes and identical twins always have the same color eyes. However, in the case of OCD, if one identical twin has the disorder, there is a 13 percent chance that the other twin will not be affected. This supports the idea that genes are only part of the cause of OCD, and that some other factor is also important. At this point, no one really knows what that other factor might be, although some have suggested that it may be a viral infection that occurs at a critical point in a child's development, or perhaps an exposure to an environmental toxin.

Some experts have speculated that there may be different types of OCD, and that some types are inherited while other types are not. Although the findings are preliminary, there is evidence that OCD which begins in childhood may be different than OCD that begins in adulthood. Individuals with childhood-onset OCD appear much more likely to have blood relatives that are affected with the disorder than are those whose OCD first appears when they are adults.

If a parent is affected with OCD we can roughly estimate how likely it will be that their child will also have the disorder. If one parent has OCD, the likelihood the child will be affected is about 2 to 8 percent. It is important to remember that this statistic is an approximation, and several other factors should be considered when attempting to estimate the risk of a child developing OCD. One factor is whether or not the parents themselves have a family history of OCD. For example, if a parent who has OCD also has blood relatives with the disorder, the risk for the child increases somewhat. Conversely, if a parent has OCD but none of his or her blood relatives are affected, then the risk decreases. Another factor is whether the parent has OCD that began when they were an adult or began when they were a child. If the parent's OCD did not start until adulthood, there is probably a decreased likelihood that his or her offspring will be affected. Conversely, if the parent's OCD is the "variety" that starts in childhood, the chances of passing the disorder on are increased.

Another factor to consider is the family history of tic disorders (such as Tourette's syndrome) or other anxiety disorders. If a child has parents or other blood relatives with tic disorders or anxiety disorders, then the child is probably at some increased risk for OCD. Conversely, having blood relatives with OCD means that not only does the child have increased risk for OCD, but may also have an increased risk for developing a different anxiety disorder or a tic disorder. In summary, having blood relatives with OCD, anxiety disorders, and tic disorders all increase a child's risk of developing any of these same disorders.

As the above information indicates, it is difficult to precisely estimate the chances that a parent will pass OCD on genetically to his or her child. This is an area of active research, and new developments appear frequently.

Because of this, prospective parents may wish to consult with a genetics counselor prior to attempting to conceive a child. This can help assure that they have the most up-to-date information available.

Behavior Therapy
Traditional psychotherapy, aimed at helping the patient develop insight into his or her problem, is generally not helpful specifically for OCD symptoms themselves. However, traditional psychotherapy may be of benefit as part of a treatment package for patients who have been ill and isolated for many years or for those whose illness started at an early age. On the other hand, behavior therapy consisting of techniques called exposure and response prevention is effective for many people with OCD.

In this approach, the patient is deliberately and voluntarily exposed to feared objects or ideas, either directly or by imagination (the exposure component), and then is discouraged or prevented (with the patient's permission) from carrying out the usual compulsive response (the response-prevention component). For example, a compulsive hand washer may be urged to touch an object believed to be contaminated, and then may be denied the opportunity to wash for several hours. When the treatment works well, the patient gradually experiences less anxiety from the obsessive thoughts and becomes able to do without the compulsive actions for extended periods of time.

Studies of behavior therapy for OCD have found it to produce lasting benefits. To achieve the best results, a combination of factors is necessary: The therapist should be well-trained in the specific method developed, the patient must be highly motivated, and the patient's family must be cooperative. In addition to visits to the therapist, the patient must be faithful in fulfilling homework assignments. For those patients who complete the course of treatment, the improvements can be significant.

With a combination of drug and behavioral therapy, the majority of OCD patients will be able to function well in both their work and social lives. The ongoing search for causes, together with research on treatment, promises to yield even more hope for people with OCD and their families.

How are OCD and depression related?
Approximately two-thirds of OCD patients have also suffered at least one major depression at some point in their life. About one-third are depressed when they present to us for treatment. Some schools of thought feel that the OCD causes the depression while others believe the OCD and depression simply tend to coexist. Most patients tell me that their OCD symptoms came first, and then depression began when they were unable to handle the OCD.

What are some signs of depression?

- Loss of appetite
- Weight loss
- Early morning awakenings
- Lack of energy
- Too much sleeping
- Sadness
- Crying, especially without knowing why
- Suicidal thoughts

- Feelings of hopelessness
- Feelings of helplessness
- Lack of interest in things that were of interest to the person
- Lack of enjoyment of life

The presence of one or more of these symptoms does not necessarily indicate depression, but if several are present, you may be depressed.

What if my OCD gets better, but I remain depressed? It sometimes happens that OCD improves and depression persists. Occasionally, a second drug is added to combat the depression. Sometimes, your doctor can assist you in finding other reasons why depression persists.

Is it possible to treat childhood OCD without medication?
Sometimes. Drugs are not the only treatment for OCD. One non-drug therapy, called cognitive-behavioral therapy (CBT), has also been shown to be effective. The cognitive-therapy component of CBT helps by challenging the catastrophic thinking and exaggerated sense of responsibility often seen in children with OCD. For example, a child may believe that taking his temperature many times per day prevents him and others from getting sick and dying. Cognitive therapy can help him to challenge the faulty assumptions behind this compulsion.

The behavioral component of CBT consists of exposing the child to real-life things that would typically lead to a compulsive ritual. For example, for a child who repeatedly takes his temperature, this could involve encouraging him to be around people he thinks are ill (as opposed to simply imagining being around ill people), and then encouraging him to refrain from taking his temperature. By being exposed to ill people, and not taking his temperature, the child learns by experience that the feared outcome of becoming sick and dying doesn't occur.

For children who don't respond adequately to cognitive-behavioral therapy alone, a combination of cognitive-behavioral therapy and medication may be helpful.

Are there delayed side effects from Anti-OCD medications?
Probably not, although no one knows for certain. There is no theoretical reason to expect long-term problems to develop. However, most of these medications haven't been around long enough to answer this question with complete assurance. Clomipramine has been in use the longest (about 30 years), and the only delayed side effect reported has been a gradual weight gain in some individuals. Fluoxetine and fluvoxamine have been in widespread use for more than 10 years (fluvoxamine primarily in Europe and Canada), and delayed problems have not been reported. Sertraline and paroxetine have not been available as long, but delayed side effects have not been reported with these medications either.

Which Anti-OCD medication should be used first?
As mentioned previously, a child's response to each of the anti-OCD medications varies. Some children will respond to all of them, some will respond to only one, and some respond to none at all. Because of this, and because the occurrence of side effects varies from child to child, there is no best drug to start with. Instead, the decision of which drug to use first is made on a case-by-case basis. There are, however, some considerations that guide physician decision-making regarding the selection of medication. These include:

- Whether there was a positive response to a particular drug by other family members
- The presence of other problems besides OCD (i.e., clomipramine may help a child with insomnia get to sleep)
- The potential for side effects (i.e., clomipramine's potential to cause constipation)
- The physician's prior successes or experience with a particular drug
- Concerns about the child attempting suicide via an overdose
- The cost or availability of the drug (i.e., some health-care providers only allow their pharmacies to dispense a particular anti-OCD drug)
- The FDA approval status of the drug (presently favors clomipramine, fluvoxamine, and sertraline) What should be done if the first medication did not work? When this happens, several things should be considered:
- Has enough time passed? All anti-OCD medications take time to work.
- If the child has been taking the medication less than 8 weeks, the best course may be simply to do nothing but wait until at least 12 weeks have passed (assuming that the child has been taking an adequate dose).
- Is the child actually taking the medication? A common saying among physicians is, "Half of the patients take half of the medication, half of the time." Obviously, an anti-OCD medication will not work if is not taken. This is most often a problem for adolescents who may be busy and very distracted, or ambivalent about taking medication.
- Is the dose appropriate? The best dose of anti-OCD medication varies widely from child to child. If there has been no benefit-and no side effects-a dose increase may help. Childhood OCD is typically treated with the same doses of medication used to treat adult OCD. However, "going low and slow" in regard to drug treatment is always a prudent maxim to follow.

- Is a cognitive-behavioral therapy program in place? A few children will feel better and yet continue to perform their OCD compulsions out of habit. It is as though they are better, but don't know it. In these situations, the behavioral-therapy component of cognitive-behavioral therapy can help the child experience the fact that they are better, and help them to realize that they need not perform these rituals.

Sometimes, even after all of the above considerations have been explored, the first medication chosen may not work. As stated earlier, moving on to a trial of one of the other anti-OCD medications is often a reasonable choice. Rarely, this process may need to be repeated once or twice before a satisfactory anti-OCD response is achieved.

WHAT IF MY CHILD WON'T SWALLOW PILLS?
One approach would be to use the liquid preparation of fluoxetine.
Liquids can be dispensed in small amounts the child can tolerate, and avoids the discomfort of taking pills. An alternative approach would be to crush a tablet between two spoons, or pull apart and empty a gelatin capsule that can then be added to a spoonful of apple sauce or jelly.

Can children under the age of six take Anti-OCD medication?
Because it is quite difficult to make the diagnosis of OCD in very young children, medications are rarely considered for this age group. Occasionally, OCD can be diagnosed in a very young child, and medication may be recommended. However, there is little information in the medical literature regarding the use of anti-OCD medications in preschool children, and it should only be considered in situations where the child is experiencing significant disability and/or distress. In these situations, a medical second opinion is often helpful.

What are the Behavioral side effects (BSES)?
These are side effects that can occur with any of the anti-OCD drugs, and are characterized by a significant change in the child's behavior. Some parents have described their child as being "too happy" or "giddy." Some have said their child became "mouthy," impertinent, or provocative while taking an anti-OCD medication. Increased aggressiveness has also been described. Some degree of BSE probably occurs in 50 percent of children treated with anti-OCD medication. Most of the time, these side effects are mild and require no specific treatment, but occasionally they can be severe.

High anti-OCD medication doses or the age of the child may be contributing factors, so starting low and going slow when administering medication should always be a consideration.

If a marked behavioral change occurs that seems out of character, the possibility of BSEs should be considered. When treating BSEs, reducing the dose is usually the first step. If that is not helpful, switching to an alternative medication is another option, although there is probably an increased likelihood that the new drug will also cause BSEs. Sometimes, adding a medication to control the BSEs (such as lithium) may be the best alternative, but this is only done if the OCD symptoms are much improved by the anti-OCD drug.

Will these children be on these medications forever?
Perhaps. Because OCD is a chronic condition and anti-OCD medications do not typically cure it, the child may need to take medication indefinitely. This is because when medication is withdrawn, the OCD symptoms usually return to their pre-drug level of severity.

Many physicians advocate that anti-OCD treatment should continue for at least one year, provided of course that the drug is working well. After a year of treatment, often during summer vacation-or at another time when an increase in OCD symptoms would be least likely to disrupt the child's life-the dose of the drug can be slowly lowered to see if it is still being helpful. If OCD symptoms return, the dose is raised again. Lowering the dose on a yearly basis benefits the child in several ways:

- Assures the doctor, child, and parents that the drug is still needed
- Adjusts the dose of medication to the lowest effective level
- Prevents needless medication taking (occasionally OCD does go away)
- Allows the child the opportunity to see if cognitive-behavioral therapy techniques (without medication) will be effective if OCD symptoms recur
- Minimizes the child's exposure to anti-OCD drugs

In some cases the Anti-OCD drugs have helped their clients a little but the child still has OCD symptoms. What should be done?
Perhaps nothing. These medications can take up to 12 weeks to become fully effective, and waiting may be the best option. It is important to understand that these medications typically do not completely eliminate OCD symptoms. Rather, they reduce them to a manageable level. Often times, these residual OCD symptoms are effectively controlled with cognitive-behavior therapy.

Are these drugs dangerous if an overdose occurs?
Yes, although clomipramine is by far the most dangerous. Any medication overdose should be viewed as a medical emergency, and the child should be taken to an emergency room without delay. With proper treatment, complete recovery is the rule, although clomipramine overdoses can result in seizures, cardiac arrest, and even death. To avoid overdose, medications should always be kept safely out of the reach of small children, and an adult should always supervise the taking of medication by a child. For children with OCD, it is usually OK to treat an occasional headache with acetaminophen (Tylenol). However, other medications may contain ingredients that interact adversely with anti-OCD drugs. A complete list of medications that can interact with anti-OCD medications is impossible to list in a pamphlet of this size. It is always best to consult with the doctor or pharmacist before combining medications. The following is a list of some of the common ingredients found in many medications that are known to interact with anti-OCD medications:

- Caffeine (Interaction primarily with Fluvoxamine [Luvox®]: Probably OK with other anti-OCD medications), and can lead to sweating, nervousness, trembling, and insomnia.
- Dextromethorphan: Can lead to extreme anxiety, chest, and abdominal discomfort.
- Phenylpropanolamine: Can lead to extreme nervousness. It is important to be aware that combining medications of any kind-including over-the-counter ones-can complicate the treatment of OCD.

For example, if unanticipated side effects occur, it can be difficult to determine which of the medications is the culprit. To avoid this problem, all of the physicians involved in the health care of the child should be made aware of all the medications the child is taking. This not only includes psychiatric medications, but also asthma medications, antibiotics, over-the-counter cough medicines, anti-acne medications, and all others.

In conclusion, because OCD symptoms are often times still a significant problem for children treated with single anti-OCD medications, and because the symptoms of comorbid psychiatric disorders or additional illnesses can also be significant problems, drug combinations are sometimes required when treating children with OCD. Unfortunately, the use of medication combinations is not well researched in children. Because of this, it is difficult to make specific recommendations on the use of medication combinations. Instead, the decision to use them should be determined on a case-by-case basis in collaboration with a physician familiar with the treatment of childhood OCD.

INTERESTING FACTS ABOUT OCD (key points reviewed)
Although adults realize in part that these obsessions and compulsions are senseless, they have great difficulty stopping them. Children with OCD may not realize their behavior is unusual.

- There is a link between serotonin and dopamine, brain neurotransmitter chemicals, and OCD.
- Often OCD affects the family. Family members are sometimes drawn into the OCD behavior. Disability may affect family finances.
- Medication for OCD should be tried 10-12 weeks before judging effectiveness.
- OCD affects men and women equally.
- OCD can start at any age. In one third of adult patients the symptoms begin in childhood, adolescence or young adulthood.
- OCD afflicts approximately 2% of the population.
- The untreated symptoms may vary for years. The symptoms may go away, remain the same or worsen.
- Evidence suggests that OCD runs in some families and may be genetically inherited.
- It is not uncommon for a person with OCD to also have clinical depression, panic attacks, or both.
- Persons having OCD often cleverly hide their OCD successfully from family and friends and coworkers
- Few OCD patients respond to placebos in contrast to 30 - 40% of depressed patients.
- Persons having OCD often exhibit abnormal rates of metabolic activity in the frontal lobe and the basal ganglia of the brain.

Some patients actually need nothing more than the medication. They make a full recovery and need no further treatment. Other OCD patients would definitely benefit from behavioral treatment called exposure and response prevention.

Exposure and response prevention mean that you expose yourself to whatever situation triggers the problem. You then prevent yourself from engaging in your usual ritual. For example, suppose that you have OCD problems with greasy substances. You might choose to allow yourself to become greasy while adding oil to your lawnmower (exposure). Instead of washing immediately, you prevent yourself from washing (response prevention).

By exposing yourself to your fear, anxiety increases temporarily. However, by continuing to avoid your usual compulsive behavior response, your anxiety is allowed to naturally diminish. The obsessive-compulsive cycle is broken, and the obsessive thoughts weaken. Confronting such fears is not easy and it may require special guidance from a trained professional.

A Screening Test for Obsessive-Compulsive Disorder

People who have Obsessive Compulsive Disorder (OCD) experience recurrent, unpleasant thoughts (obsessions) and feel driven to perform certain acts over and over again (compulsions). Although sufferers usually recognize that the obsessions and compulsions are senseless or excessive, the symptoms of OCD often prove difficult to control without proper treatment. Obsessions and compulsions are not pleasurable; on the contrary, they, are a source of distress. The following questions are designed to help people determine if they have symptoms of OCD and could benefit from professional help.		
Part A. Please circle YES or NO. Have you been bothered by unpleasant thoughts or images that repeatedly enter your mind, such as:		
1. concerns with contamination (dirt, germs, chemicals, radiation) or acquiring a serious illness such as AIDS?	YES	NO
2. over concern with keeping objects (clothing, groceries, tools) in perfect order or arranged exactly?	YES	NO
3. images of death or other horrible events?	YES	NO
4. personally unacceptable religious or sexual thoughts?	YES	NO
Have you worried a lot about terrible things happening, such as:		
5. fire, burglary, or flooding the house?	YES	NO
6. accidentally hitting a pedestrian with your car or letting it roll down the hill?	YES	NO
7. spreading an illness (giving someone AIDS)?	YES	NO
8. losing something valuable?	YES	NO
9. harm coming to a loved one because you weren't careful enough?	YES	NO
Have you worried about acting on an unwanted and senseless urge or impulse, such as:		
10. physically harming a loved one, pushing a stranger in front of a bus, steering your car into oncoming traffic; inappropriate sexual contact; or poisoning dinner guests?	YES	NO
Have you felt driven to perform certain acts over and over again, such as:		
11. excessive or ritualized washing, cleaning, or grooming?	YES	NO
12. checking light switches, water faucets, the stove, door locks, or emergency brake?	YES	NO
13. counting; arranging; evening-up behaviors (making sure socks are at same height)?	YES	NO
14. collecting useless objects or inspecting the garbage before it is thrown out?	YES	NO
15. repeating routine actions (in/out of chair, going through doorway, re-lighting cigarette) a certain number of times or until it feels just right	YES	NO
16. need to touch objects or people?	YES	NO
17. unnecessary re-reading or re-writing; re-opening envelopes before they are mailed?	YES	NO
18. examining your body for signs of illness?	YES	NO

19. avoiding colors ("red" means blood), numbers ("l 3" is unlucky), or names (those that start with "D" signify death) that are associated with dreaded events or unpleasant thoughts?	YES	NO
20. needing to "confess" or repeatedly asking for reassurance that you said or did something correctly?	YES	NO

If you answered YES to 2 or more of the above questions, please continue with Part B.

A Screening Test for Obsessive-Compulsive Disorder

Part B. The following questions refer to the repeated thoughts, images, urges, or behaviors identified in Part A. Consider your experience during the past 30 days when selecting an answer. Circle the most appropriate number from 0 to 4.					
On average, how much time is occupied by these thoughts or behaviors each day?	0 None	1 Mild (less than 1 hour)	2 Moderate (1 to 3 hours)	3 Severe (3 to 8 hours)	4 Extreme (more than 8 hours)
How Much distress do they cause you?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme (disabling)
How hard is it for you to control them?	0 Complete control	1 Much control	2 Moderate control	3 Little control	4 No control
How much do they cause you to avoid doing anything, going any place, or being with anyone?	0 No avoidance	1 Occasional avoidance	2 Moderate avoidance	3 Frequent and extensive	4 Extreme (housebound)
How much do they interfere with school, work or your social or family life?	0 None	1 Slight interference	2 Definitely interferes with functioning	3 Much interference	4 Extreme (disabling)
Sum on Part B (Add items 1 to 5): **Scoring:** If you answered YES to 2 or more of questions in Part A and scored 5 or more on Part B, you may wish to contact your physician, a mental health professional, or a patient advocacy group (such as, the Obsessive Compulsive Foundation, Inc.) to obtain more information on OCD and its treatment. Remember, a high score on this questionnaire does not necessarily mean you have OCD--only an					

evaluation by an experienced clinician can make this determination. copyright, Wayne K. Goodman, M.D., 1994, University of Florida College of Medicine

Is OCD commonly recognized by professionals?
Not nearly commonly enough. OCD is often misdiagnosed, and it is often under diagnosed. Many people have dual disorders of OCD and schizophrenia, or OCD and bipolar disorder, but the OCD component is not diagnosed or treated. Researchers believe OCD, anxiety disorders, Tourette's, and eating disorders such as anorexia and bulimia can be triggered by some of the same chemical malfunctioning of the brain.

What is behavior therapy, and can it effectively relieve symptoms of OCD?
Behavior therapy is not traditional psychotherapy. It is "exposure and response prevention," and it is effective for many people with OCD. Consumers are deliberately exposed to a feared object or idea, either directly or by imagination, and are then discouraged or prevented from carrying out the usual compulsive response. For example, a compulsive hand-washer may be urged to touch an object he or she believes is contaminated and denied the opportunity to wash for several hours. When the treatment works well, the consumer gradually experiences less anxiety from the obsessive thoughts and becomes able to refrain from the compulsive actions for extended periods of time.

Several studies suggest that medication and behavior therapy are equally effective in alleviating symptoms of OCD. About half of the consumers with this disorder improve substantially with behavior therapy; the rest improve moderately.

Medications

Anafranil (clomipramine): A tricyclic antidepressant, Anafranil has been shown to be effective in treating obsessions and compulsions. The most commonly reported side effects of this medication are dry mouth, constipation, nausea, increased appetite, weight gain, sleepiness, fatigue, tremor, dizziness, nervousness, sweating, visual changes, and sexual dysfunction. There is also a risk of seizures, thought to be dose-related. People with a history of seizures should not take this medication. Anafranil should also not be taken at the same time as a monoamine oxidase inhibitor (MAOI).

Many of the antidepressant medications known as selective serotonin reuptake inhibitors (SSRIs) have also proven effective in treating the symptoms associated with OCD. The SSRIs most commonly prescribed for OCD are Luvox (fluvoxamine), Paxil (paroxetine), Prozac (fluoxetine), and Zoloft (sertraline).
Luvox (fluvoxamine): Common side effects of this medication include dry mouth, constipation, nausea, sleepiness, insomnia, nervousness, dizziness, headache, agitation, weakness, and delayed ejaculation.
Paxil (paroxetine): Side effects most associated with this medication include dry mouth, constipation, nausea, decreased appetite, sleepiness, insomnia, tremor, dizziness, nervousness, weakness, sweating, and sexual dysfunction.
Prozac (fluoxetine): Dry mouth, nausea, diarrhea, sleepiness, insomnia, tremor, nervousness, headache, weakness, sweating, rash, and sexual dysfunction are among the more common side effects associated with this drug.
Zoloft (sertraline): Among the side effects most commonly reported while taking Zoloft are dry mouth, nausea, diarrhea, constipation, sleepiness, insomnia, tremor, dizziness, agitation, sweating, and sexual dysfunction. SSRIs should never be taken at the same time as MAOIs.

For further information:
The Boy Who Couldn't Stop Washing, by Judith L. Rapoport, M.D. New American Library, 1977.
Obsessive-Compulsive Disorder: The Facts, by Padmal de Silva and Stanley Rachman. Oxford University Press, 1998.
Polly's Magic Games: A Child's View of Obsessive-Compulsive Disorder, by Constance H. Foster. Illustrated by Edwin A. Chase. Dilligaf Publishing, 1994.
Tormenting Thoughts and Secret Rituals: The Hidden Epidemic of Obsessive-Compulsive Disorder, by Ian Osborn, M.D. Delacorte Press, 1999.

For further information on OCD, its treatment, and how to get help, you may wish to contact the following organizations:
Anxiety Disorders Association of America
11900 Parklawn Drive, Suite 100
Rockville, MD 20852
Telephone: 301-231-9350
http://www.adaa.org

Makes referrals to professional members and to support groups. Has a catalog of available brochures, books, and audiovisuals.

Association for Advancement of Behavior Therapy
305 Seventh Ave.
New York, NY 10001
Telephone 212-647-1890
http://server.psyc.vt.edu/aabt/

Membership listing of mental health professionals focusing on behavior therapy.

Madison Institute of Medicine
Obsessive Compulsive Information Center
7617 Mineral Point Road, Suite 300
Madison, WI 53717-1914
Telephone: 608-827-2470
Fax: 608-827-2479
http://healthtechsys.com/mimocic.html

Computer data base of over 13,000 references updated daily. Computer searches done for nominal fee. No charge for quick reference questions. Maintains physician referral and support group lists.

Freedom From Fear
308 Seaview Ave.
Staten Island, NY 10305
Telephone: 718-351-1717
http://www.freedomfromfear.com

Offers a free newsletter on anxiety disorders and a referral list of treatment specialists.

Obsessive-Compulsive Foundation
P.O. Box 70
Milford, CT 06460-0070
Telephone: 203-878-5669
Fax: 203-874-2826
InfoLine: 203-874-3843
http://ocfoundation.org

Offers free or at minimal cost brochures for individuals with the disorder and their families. In addition, videotapes and books are available. A bimonthly newsletter goes to members who pay an annual membership fee of $45.00. Has over 250 support groups nationwide. Can refer to mental health professionals and treatment facilities in your area with experience in treating OCD by mail.

Tourette Syndrome Association, Inc.
42-40 Bell Boulevard
New York, NY 11361-2874
Telephone: 800-237-0717
http://ba.mgh.harvard.edu

Publications, videotapes, and films available at minimal cost. Newsletter goes to members who pay an annual fee of $45.00.

Trichotillomania Learning Center
1215 Mission Street, Suite 2
Santa Cruz, CA 95060-3558
Telephone: 831-457-1004
E-mail: trichster@aol.com
http://www.trich.org

Membership fee of $35.00 includes information packet and bimonthly newsletter.

For information on other mental disorders, contact:

Information Resources and Inquiries Branch
National Institute of Mental Health
6001 Executive Boulevard, Rm. 8184, MSC 9663
Bethesda, MD 20892-9663
Telephone: 301-443-4513
e-mail: nimhinfo@nih.gov

UCLA Obsessive-Compulsive Disorder Program

The UCLA Neuropsychiatric Institute & Hospital is one of the world's leading centers for comprehensive patient care, research and education in the fields of mental health and developmental disabilities. In fact, it was recently named the number one psychiatric facility in the West by US News and World Report.

The UCLA Obsessive-Compulsive Disorder (OCD) Program is a highly specialized program for the treatment of people with OCD. The program is designed to accommodate people with all types of OCD and any severity from mild to severe.

The program is run by therapists skilled in the techniques of cognitive behavior therapy and physicians who specialize in the medication management of anxiety disorders. The behavior therapy is usually done in the form of Exposure and Response Prevention (ERP). There are a variety of different clinical settings:

- inpatient
- partial
- outpatient
- research
- support groups

The OCD Program has 2 departments:

- Adult OCD program
- Child and Adolescent OCD Program

The OCD Program is part of the UCLA Anxiety Disorders Program which consists of several Clinical Research Centers that closely collaborate.

UCLA OCD Treatment Unit (310) 794-7305

UCLA Inpatient Program Dr. Gerald Tarlow (310) 208-4077

UCLA OCD Support/ Aftercare Group Ruth Wolson, RN MN (310) 206-1602.

Family Support Group and OCD Oupatient Program (310) 794-7305.

UCLA Outpatient Anxiety Disorders Clinic (310) 794-1474

Books Suggested for Further Reading

Baer L. Getting Control. Overcoming Your Obsessions and Compulsions. Boston: Little, Brown & Co., 1991.

DeSilva P and Rachman S. Obsessive-compulsive Disorder: that Facts. Oxford: Oxford University Press, 1992.

Foa EB and Wilson R. Stop Obsessing! How to Overcome Your Obsessions and Compulsions. New York: Bantam Books, 1991.

Foster CH. Polly's Magic Games: A Child's View of Obsessive-Compulsive Disorder. Ellsworth, ME: Dilligaf Publishing, 1994.

Greist JH. Obsessive Compulsive Disorder: A Guide. Madison, WI: Obsessive Compulsive Disorder Information Center. rev. ed., 1992. (Thorough discussion of pharmacotherapy and behavior therapy)

Jenike MA. Drug Treatment of OCD in Adults. Milford, CT: OC Foundation, 1996. (Answers frequently asked questions about OCD and drug treatments)

Johnston HF. Obsessive Compulsive Disorder in Children and Adolescents: A Guide. Madison, WI: Child Psychopharmacology Information Center, 1993.

Matisik EN. The Americans with Disabilities Act and the Rehabilitation Act of 1973: Reasonable Accommodation for Employees with OCD. Milford, CT: OC Foundation, 1996.

Neziroglu F. and Yaryura-Tobias JA. Over and Over Again: Understanding Obsessive-compulsive Disorder. Lexington, MA: DC Health, 1991.

Rapoport JL. The Boy Who Couldn't Stop Washing: The Experience and Treatment of Obsessive-Compulsive Disorder. New York: E.P. Dutton, 1989.

Steketee GS and White K. When Once Is Not Enough: Help for Obsessive Compulsives. Oakland, CA: New Harbinger, 1990.
VanNoppen BL, Pato MT, and Rasmussen S. Learning to Live with OCD. Milford, CT: OC Foundation, 1993.

References

DuPont RL, Rice DP, Shiraki S, and Rowland C. Economic costs of obsessive-compulsive disorder. Unpublished, 1994. Foa EB and KoZak MJ. Obsessive-compulsive disorder: long-term outcome of psychological treatment. In Mavissakalian & Prien (Eds.), Long-term Treatments of Anxiety Disorders. Washington, DC: American Psychiatric Press, 1996, 285-309.

Hiss H, Foa EB, and Kozak MJ. Relapse prevention program for treatment of obsessive-compulsive disorder. Journal of Consulting and Clinical Psychology 62:4:801-808, 1994.

Jenike MA. Obsessive-compulsive Disorder: efficacy of specific treatments as assessed by controlled trials. Psychopharmacology Bulletin 29:4:487-499, 1993.

Jenike MA. Managing the patient with treatment-resistant obsessive-compulsive disorder: current strategies. Journal of Clinical Psychiatry 55:3 (suppl):11-17, 1994.

Jenike MA et al. Cerebral structural abnormalities in obsessive-compulsive disorder. Archives of General Psychiatry 53:7:625-632, 1996.

Leonard HL, Swedo SE, Lenane MC, Rettew DC, Hamburger SD, Bartko JJ, and Rapoport JL. A 2- to 7-Year follow-up study of 54 obsessive-compulsive children and adolescents. Archives of General Psychiatry 50:429-439, 1993.

March JS, Mulle K, and Herbel B. Behavioral psychotherapy for children and adolescents with obsessive-compulsive disorder: an open trial of a new protocol-driven treatment package. Journal of the American Academy of Child and Adolescent Psychiatry 33:3:333-341, 1994.

Pato MT, Zohar-Kadouch R, Zohar J, and Murphy DL. Return of symptoms after discontinuation of clomipramine in patients with obsessive-compulsive disorder. American Journal of Psychiatry 145:1521-1525, 1988.

Swedo SE and Leonard HL. Childhood movement disorders and obsessive-compulsive disorder. Journal of Clinical Psychiatry 55:3 (suppl):32-37.

Swedo SE and Leonard HL. Excessively compulsive or obsessive-compulsive disorder? It's Not All in Your Head. New York, NY: HarperCollins, 1996.