CHAPTER 3

What Can Be Done? Treatment Options

Do the thing we fear, and the death of fear is certain.

—Ralph Waldo Emerson

OCD was once considered a hopeless, untreatable psychiatric illness, but the last three decades have brought huge progress in the effective treatment of OCD. Considerable clinical and scientific evidence has demonstrated that cognitive behavioral therapy combined with medications can be an effective treatment. Thanks to these developments, many people with OCD now live productive and useful lives.

The word "cognitive" in cognitive behavioral therapy refers to specific methods and techniques that help change faulty ideas and beliefs, including those prevalent in OCD. The word "behavior" refers to specific methods for changing behavior or the actions, such as the compulsive rituals of OCD. Cognitive behavioral therapy includes many approaches and techniques. The one considered most effective in the treatment of OCD is exposure and response prevention (ERP), also referred to at times as exposure and ritual prevention. The self-directed program presented in this book employs many cognitive behavioral therapy techniques, including exposure and response prevention.

In this chapter, we'll take a closer look at cognitive behavioral therapy. We'll also summarize how medications are currently used in treating OCD. While the latter information may be helpful to you,

it is vitally important that you consult with your prescribing physician to determine the specific OCD medication that is right for you.

This chapter also addresses talk therapy and its limitations with OCD, and neurosurgery—an extreme and invasive approach generally appropriate in only the most disabling and resistant cases. We'll also touch upon so-called alternative treatments, none of which have been proven effective for OCD. We want you to be well informed about all of these choices, because the wrong treatment can be harmful.

MEDICATION TREATMENTS

The most effective medications for treating OCD are in the class of drugs known as antidepressants, specifically, the *selective serotonin reuptake inhibitors* (SSRIs). The most commonly used SSRIs are fluvoxamine (Luvox), fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), citalopram (Celexa), and escitalopram (Lexapro). Venlafaxine (Effexor), duloxetine (Cymbalta), and other antidepressants may also be useful, but more study is needed.

Clomipramine (Anafranil), the first successful medication for OCD, belongs to an older family of drugs known as tricyclic antidepressants. It has been used all over the world since the 1970s and was approved for use in the United States in 1990. It was considered the first breakthrough drug in the treatment of OCD. It has a powerful effect on serotonin levels but also has effects on dopamine and other chemical messengers in the brain. The next generation of drugs target serotonin specifically and have fewer adverse side effects, hence the term "selective serotonin reuptake inhibitors," because they are selective in their action on the brain chemical serotonin. They seem to work by making more serotonin available in the brain.

Here is a brief overview of how these medications help with OCD. Let's start by reviewing the information from chapter 2 about the role of serotonin. Serotonin is one of the neurotransmitters, or chemical messengers, that nerve cells in the brain use to communicate with each other. These neurotransmitters are active when they are present in the small space between two nerve cells, called the synaptic cleft. For one nerve cell to communicate with another, various neurotransmitters must be released into the synaptic cleft. When this communication or transmission between cells is completed, the chemicals are taken back up into the transmitting cell in a process called reuptake. Clomipramine and the SSRIs slow the reuptake of serotonin, making more of it available to the receiving cell, and thus prolonging its effects on the brain.

Increasing the amount of available serotonin appears to produce changes in certain structures at the nerve endings called receptors. Think of the receptors as a lock, and serotonin as the chemical key to that lock. To have proper transmission of impulses from one cell to another, there must be a perfect fit between the chemical key and the receptor lock. Further complicating the situation, specific serotonin receptors may be abnormal in people with OCD.

For any given patient, a particular SSRI may not do the trick but another might, so it could be worth trying a different SSRI if the first one isn't effective. A particular SSRI may also affect other brain chemicals important to that "perfect fit" of serotonin and receptor for any given individual. This is why someone may respond to one medication and not to another. You may have to try two or more SSRIs before finding one that works for you.

If none of the SSRIs sufficiently relieves symptoms, other medications may be used in combination with an SSRI to give it a boost. A class of drugs known as atypical antipsychotics, mainly used to treat schizophrenia, are playing an increasing role as adjunctive agents in the treatment of OCD. Your doctor should be knowledgeable about safely combining different medications to best help you with your OCD.

Dosages

High dosages of antidepressants are usually needed to relieve OCD symptoms—higher than the dosages typically used to treat depression. However, some people are very sensitive to side effects at even the lowest dosages. Starting with the lowest dose possible—even breaking pills in half—and gradually increasing the dosage may be effective. Several SSRIs (fluoxetine, citalopram, escitalopram, and paroxetine) also come in liquid form, which makes it possible to start at a very low dose.

Note that a very small number of people who don't experience a reduction of OCD symptoms with large dosages report good results with extremely low doses. The reasons for this aren't well understood, and this result is atypical. First-time users are generally advised to aim for eventually taking the highest dose tolerable.

Medications may take up to twelve weeks to begin working. During the first few weeks, you may experience side effects but no relief of your OCD symptoms. Even physicians may be tempted to give up on the medication too soon, since it usually takes only four to six weeks for people with depression to improve. Even if you aren't experiencing any reduction in symptoms, don't stop taking the medication without consulting your doctor. When these medications are stopped, it's generally important to reduce the level gradually to avoid withdrawal.

Dealing with Side Effects

All medications can cause side effects, and those used to treat OCD are no different. For most people the side effects are mild and tolerable, but for a few they may be quite severe. If side effects are intolerable with one medication, you may tolerate another medication much better. In addition, the side effects often diminish or disappear after you've been on the medication for a while, so give it some time. Many people with OCD needlessly fear and avoid medication because of the possibility of side effects, or they don't keep taking it long enough for their bodies to adjust to it. However, most people who improve and remain on the medication report that the benefits far outweigh problems with side effects.

Be sure to notify your doctor of any uncomfortable side effects or unusual symptoms you have. He or she will let you know if they're dangerous or if your medication needs adjusting. Adjusting the dosage, dividing the dosage over the course of the day, and changing the time of day you take the medication can often relieve side effects. However, these changes must not be made without consulting your doctor. Should you need to stop the medication, you will probably need to discontinue it slowly to avoid withdrawal effects, which may include nausea, vomiting, hyperthermia, headache, sleep problems, and malaise.

Don't allow side effects to deter you from taking medication to treat your OCD. Most side effects are transient and can be dealt with effectively. Tell your doctor about any symptoms you think may be caused by your medications. If they're severe, your doctor may reduce your dosage, supplement what

you're taking with another medication or change the medication altogether. Here are the most common side effects and tips for managing them.

Sleep problems. Medications used to treat OCD may cause some people to have difficulty sleeping. If this happens, ask your doctor if you can change the time of day when you take your medication. In general, medications that can activate your system are best taken in the morning, and sedating medications are best taken at bedtime. Be aware that there are individual variations in how people react to medication. A medication that makes some people sleepy may make others feel wide awake.

Restlessness. Some people feel restless or wired on medications that treat OCD, at least initially. Some even experience a temporary increase in their OCD symptoms, lasting a few hours or a few days. If the restlessness and nervousness are severe, your doctor may want to prescribe another medication to be taken temporarily to help you relax.

Weight fluctuations. Be prepared for changes in your appetite. Many people gain weight on SSRIs, while others temporarily lose weight. Adjust your diet and exercise program before you start taking medications that may cause weight gain. If you expect it and take precautions, you are less likely to gain weight—or at least you may not gain as much. Some medications, such as the antiepileptic topiramate (Topamax) and the aminoketone antidepressant bupropion (Wellbutrin), have been known to cause weight loss as a side effect. Your doctor may consider prescribing one of these if you gain weight. Cherry Pedrick gained about thirty pounds the first two years she took SSRIs. Diet and exercise helped her lose the added weight. The weight gain probably wasn't solely due to the medication. It also seemed to be related to depression. When she was very depressed, she lost weight. As she began to feel better, she ate more, and she also ate when she was nervous and anxious. Like many others on SSRIs, she craved carbohydrates, especially sweets. But, for her, this was partly an excuse. She needed to take back control of her diet. When she did, she lost the added weight.

Dry mouth. This common and bothersome side effect of some OCD medications is caused by a reduction of saliva. Sipping on fluids helps relieve the dryness. Sucking on hard candies may help. Try sugar-free candies to avoid tooth decay. Because saliva helps fight plaque and hardens teeth, reduction in amounts of saliva can lead to dental problems. If dry mouth is more than a bit bothersome, your doctor may recommend an artificial saliva to moisten your mouth.

Nausea. Taking your medication with a small amount of food can help control nausea. Rest a bit after taking the medication, but don't lie down, as this can cause heartburn.

Heartburn. If heartburn becomes a problem, don't lie down for two hours after eating or taking medications. You can relieve heartburn at night by adding an extra pillow under your head. If heartburn persists, ask your doctor about medications to relieve it.

Constipation. There are many things you can do to help prevent constipation. Eat a diet high in fiber, fruits, vegetables, and liquids. High-fiber foods include raw vegetables, fruits, and whole grains. Exercise will help too. If these don't relieve your constipation, ask your doctor about taking a fiber supplement or stool softener.

Diarrhea. If you have diarrhea, eat low-fiber foods, such as bananas, and avoid high-fiber foods. Apply petroleum jelly to the anus after bowel movements if you experience soreness, itching, pain, or a burning sensation. Drink plenty of fluids to avoid dehydration. Notify your doctor if you experience weakness, dizziness, or decreased urine output. These can be signs of dehydration. If your diarrhea is persistent, ask your doctor about taking antidiarrheal medications.

Dizziness. Lowered blood pressure, a fast pulse, dehydration due to diarrhea, or nonsymptomatic effects of the medication can lead to dizziness. Notify your doctor to make certain the dizziness is nothing to be overly concerned about. Make sure you're drinking enough fluids. Take precautions to prevent falls or accidents, such as standing up slowly and waiting a few seconds before starting to walk. Don't drive when you're likely to feel dizzy or sleepy.

Sexual dysfunction. Clomipramine and the SSRIs often produce sexual side effects in both men and women. These include lowered sex drive, delayed orgasm, and complete inability to have an erection or orgasm. On the other hand, some people will have increased interest in sexual activity. If you experience these side effects, discuss them with your doctor. Don't be embarrassed; realize that your doctor won't be surprised, as this is common with many medications. Your doctor may be able to prescribe a medication, such as sildenafil (Viagra), to counteract the sexual dysfunction. Some people have been able to reduce sexual side effects and enjoy sexual activity on the weekends by stopping the medication on Fridays and Saturdays. This isn't as effective with fluoxetine because it is longer acting. As always, don't adjust your medication without your doctor's approval and supervision.

Medication Precautions

The medication you take to treat your OCD is an important part of your recovery plan. A few simple precautions will make the medication safer and more effective. When taking any medication, ask your doctor (and pharmacist) to provide you with information about the medication. Here are some questions that we recommend you ask your doctor:

- How does this medication help with OCD symptoms?
- How long does it usually take to see positive effects?
- What is the dosage and how often do I take it?
- How long will I have to remain on the medication, and what is likely to happen if I stop taking it?
- What if the medication doesn't work?
- What are the potential side effects of the medication?
- Which side effects are dangerous? Which should I report immediately?
- What can I do to reduce the severity of side effects?
- Are there any dietary restrictions when taking this medication?

- Will I need any tests before starting this medication or while taking it?

Although doctors are obligated to provide information, you also need to give them information that will aid them in choosing the right medication for you. Notify your doctor of any of the following:

- Any known allergies
- Any other medications you take, even nonprescription medicines
- If you are pregnant, trying to become pregnant, or breastfeeding
- If you have a seizure disorder or heart murmur
- Any other medical or psychiatric problems

The doctor prescribes the medication, but you're the one taking it. Here are some precautions you can take to ensure optimum treatment:

- Make certain the doctor prescribing medication for OCD is a psychiatrist or is very experienced in the treatment of psychiatric disorders.
- Ask your doctor to write out the name of the medication, the dosage, and how often you are to take it. When you get the prescription filled, compare it with what the doctor wrote.
- Provide the doctor with complete medical history, as some medical conditions can seriously affect the doctor's choice of medication for you.
- Report any side effects or new symptoms to your doctor. If you aren't sure a symptom is related to the medication, give your doctor a call.
- Know who you should call if your doctor isn't available.
- Get any tests your doctor recommends before you start the medication and while you are taking it, for example, blood tests and electrocardiograms.
- Tell all of your doctors what medications you're taking.
- Get all of your medications at the same pharmacy. Having one pharmacist who knows all of the medications you take can help you avoid drug interactions.
- Know what your medication looks like. Sometimes you may get the same medication made by a different company. If the tablets or capsules look different than usual, ask your pharmacist about it.
- Don't quit taking any medication or change the dosage without consulting your doctor.
- Ask your doctor before taking any other medication, even over-the-counter medicines.
- Ask your doctor what you should do if you forget to take your medication.

- Let a family member or friend know what medications you're taking. Write them down so you can show the list to doctors or emergency personnel when needed.
- If a medication could make you drowsy or dizzy, adjust your activities. Until you are certain how you will react, don't drive or operate machinery.
- Keep all medications out of the reach of children and pets, even children who visit only occasionally.
- Store medications in a cool, dry place. The moisture in bathrooms may decrease the effectiveness of some medications.
- Make sure you have enough medication before vacations and holidays. Always get refills a few days ahead of time because sometimes the pharmacist must call the doctor for permission to refill the prescription.
- Keep medications in their original bottles, and be sure the label is readable.
- Read the label on the bottle before taking any medication—even those you take every day. It's easy to grab the wrong bottle, especially in the dark.
- Develop a system to help you remember when to take your medications. The weekly pillboxes sold at pharmacies, with a compartment for each day, are a great help. Fill the container at the beginning of the week, and then with just a glance you can tell if you've taken your medication on any given day. It's easy to forget routine activities that you do every day. If you take many medications, you can get a container with multiple compartments for each day.

Caution: Alcohol should be consumed only with great caution when taking medications for OCD, for a variety of reasons. If used in excess, it can interfere with the therapeutic action of the medication. Combining alcohol with medications used to treat OCD may trigger aggressive behavior. Alcohol is also known to worsen depression. In addition, alcohol can have a greater effect on individuals taking medications for OCD—one drink may have the effect of two. If you regularly consume alcohol, be sure to discuss your consumption with your prescribing physician. Consider it another chemical that can interfere with the benefits the medication offers you while you combat OCD.

Parts of the previous section were adapted from "Taking Medications Safely," by Cherry Pedrick, *Mature Years*, Fall 1999.

COGNITIVE BEHAVIORAL THERAPY

Cognitive behavioral therapy is an important part of recovery from OCD. Research by Dr. Lewis Baxter of UCLA demonstrated that behavior therapy results in positive changes in brain activity similar to those brought about by successful drug treatment (Yaryura-Tobias and Neziroglu 1997b). Cognitive behavioral therapy helps those with OCD by providing them with the tools needed to manage their obsessions and

compulsions. Continued practice and use of the tools and skills learned in CBT will help keep symptoms manageable. Successful cognitive behavioral treatment requires motivation and daily practice. Initially, it can appear quite challenging, even scary, but obtaining relief from OCD symptoms makes it worthwhile. When used together, medication and cognitive behavioral therapy complement each other. Medication can have beneficial effects on serotonin levels, while cognitive behavioral therapy helps modify behavior by teaching the person with OCD the skills to resist compulsions and obsessions. Medication can reduce anxiety levels, making it easier to implement cognitive behavioral therapy tools and techniques.

Exposure and Response Prevention

Exposure and response prevention is the principal cognitive behavioral technique for treating OCD. The purpose of ERP is to reduce the anxiety and discomfort associated with obsessions through the natural process of sensory *habituation*. Habituation, which is hardwired into the brain, is a natural process whereby the central nervous system gets used to stimuli through repeated, prolonged contact; you might even say the nervous system gets bored with these stimuli. There are endless examples of habituation at work in our daily lives. One example would be the sudden, jolting chill you feel when you dive into a pool of cold water. The sensory neurons in your skin (assigned to detect sensory information about hot and cold) send an initial barrage of temperature-related information to your brain, which interprets this to mean "Boy, this water sure is cold!" However, if you remain in the water, after a few seconds those same sensory neurons on the skin start to fatigue and the transmittal of information about hot and cold virtually stops. The chilling sensations diminish, and gradually the cold water begins to feel almost warm. Obviously, the water doesn't become warmer. Rather, your nervous system numbs out to the chilly sensations as you habituate to the cold water.

There are countless other examples. Here's one you could try right now. Take a mouthful of luscious, flavorful food in your mouth—something you really love—and hold it there for a minute without swallowing. The intense flavors eventually fade away, indicating that habituation to the sensations of flavor have occurred. Likewise, if you've ever worked with the radio blaring in the background or an airplane roaring overhead, you've probably noticed how you can be so absorbed in a task that after a while you may not even hear the continuous background noise. After prolonged, repeated contact with any physical or psychological stimulus, habituation will occur. Habituation also reliably occurs in situations that initially evoke feelings of anxiety and fear. If you stay in persistent contact with those experiences, habituation will occur, providing a natural way to overcome avoidance of anxiety-provoking situations.

EXPOSURE

You can use this process to your advantage by arranging for prolonged exposure to the real-life situations that provoke anxiety and cause you to perform rituals. This is called in vivo, or real-life, exposure. For example, a person with fears related to contamination might be asked to touch or otherwise directly contact some feared object, such as an empty garbage can, without relieving the anxiety by hand washing. Through repeated practice, the person realizes that the feared disastrous consequences don't occur, and the severe anxiety initially associated with that situation decreases.

Exposure is best done in stages, taking baby steps toward the ultimate goal of complete habituation to the feared object or situation. For example, exposure to a "contaminated" garbage can may begin with the person touching a "safe" corner with only a fingernail. Eventually, exposure progresses to touching the garbage can with a finger and waiting as long as it takes for habituation to occur. Then several fingers are used, then the front of the hand, then the back of the hand. With each step, the person confronts the fear, experiences anxiety, then experiences habituation gradually and naturally. (Note: In this book when we use the word "contaminated" in quotation marks, we mean that the person with OCD would consider the object or situation to be dirty, disgusting, dangerous, and to be avoided at all costs, while most people wouldn't consider it dangerous in any way.)

Sometimes it's either impractical or impossible to re-create the feared situation. An example is the fear of becoming sick or losing a loved one. In these cases, *imaginal exposure* is used. This involves prolonged, repeated mental visualization of the feared image or situation, again for as long as it takes for habituation to occur. In combination with in vivo exposure, imaginal exposure is also a useful technique for overcoming the fear of thoughts that so many people with OCD experience. This book offers detailed instructions on how to devise and implement both in vivo and imaginal exposure to help you break free from OCD. With patience and practice, this approach will help decrease the intensity of your obsessions.

RESPONSE PREVENTION

Think of response prevention as the act of voluntarily preventing the rituals (washing, checking, and so on) you typically perform when an obsession triggers anxiety. The purpose of response prevention is to encourage habituation to fear-provoking thoughts and situations, and to ultimately decrease the frequency of rituals. As you face feared stimuli and experience the urge to do rituals, you simultaneously refrain from ritual behaviors such as hand washing or excessive checking. At first you may simply decrease the length and frequency of a ritual as you gradually work toward totally resisting the compulsion. Ultimately, the goal of response prevention is to stop all compulsive rituals. This may sound impossible or even frightening, but with regular effort, practice, and the strong support of a coach, such as a therapist or family member, response prevention is possible—and one of the most powerful keys for breaking free of OCD.

Cognitive Restructuring

The cognitive component of cognitive behavioral therapy involves actively challenging and confronting the distorted thinking and faulty beliefs that drive and maintain obsessions and compulsions. In cognitive therapy, you are encouraged to identify faulty beliefs and replace them with more accurate and realistic appraisals. This approach is traditionally done through interactions between therapist and client in a process sometimes referred to as *cognitive restructuring*, but it's also possible to use this technique in a self-help format, as in the self-directed program in this book. Here are the key cognitive errors of people with OCD, with examples of each.

Overestimating risk, harm, and danger. Examples: "If I take even the slightest chance, something terrible is likely to happen." "The mere possibility of danger equals the probability of danger occurring."

Overcontrol and perfectionism. Example: "Whatever I do, it's intolerable unless I do it perfectly."

Catastrophizing. Examples: "An open sore on my arm means I'll definitely get AIDS if I am around someone I think has AIDS." "If I get angry with my mother, it must definitely mean I'm a violent person."

Black-and-white or all-or-nothing thinking. Examples: "If I'm not perfectly safe, then I'm in great, overwhelming danger." "If I don't do it perfectly, then I've done it horribly."

Magical thinking. Example: "If I think of a bad, horrible thought, it will certainly cause something bad or horrible to happen."

Thought-action fusion (similar to magical thinking). Example: "If I have a bad, horrible thought about harming someone, it feels just as if I've actually done it or as if it makes it more likely to happen in the future."

Overvaluing thoughts. Example: "If I think of a terrible event occurring, the likelihood that it will actually take place is very high."

Overresponsibility. Example: "I must always, at all times, guard against making a mistake that could possibly harm an innocent person, no matter how remote that possibility."

Pessimistic bias. Example: "If something bad is going to happen, it is much more likely to happen to me or to someone I love or care about than to others."

What-if thinking. Examples: "In the future, what if I make a mistake [do it wrong, get AIDS, am responsible for causing harm to someone, and so on]?"

Intolerance of uncertainty. Example: "I can't relax until I'm 100 percent certain of everything and know that everything will be okay. If I'm uncertain about *anything* (my future, my health, the health of loved ones), it is intolerable."

Hypermorality. Example: "I'll go to hell (or be punished severely) for even the slightest mistake, error, or transgression."

The "martyr complex." Example: "How noble and wonderful I am! I'll gladly suffer and sacrifice my life doing endless rituals (washing, counting, checking, and so on) all day long as a small price to pay to protect those I love from danger and harm. And since no one close to me has yet died or suffered great harm, I must be doing something right!"

While changes in OCD-related beliefs are vital to recovery, there is disagreement among clinicians and researchers as to how best to achieve those changes. Some controlled studies show that people improve just as much when they actively challenge their beliefs about the situations that cause them anxiety as when they engage actively in exposure and response prevention to those situations (van Oppen et al. 1995; Cottraux et al. 2001; Emmelkamp and Beens 1991). In other words, some experts that believe that direct exposure to fear provoking situations (like touching a "contaminated" toilet seat) may not be necessary. The approach taken in this book (and that taken by most expert clinicians in the field of OCD treatment), is that ERP is the best way to change OCD-related beliefs and behaviors, but that there is also an important role for actively examining and challenging the faulty beliefs that maintain symptoms (described in chapter 8), especially for people with overvalued ideas or those who find exposure too challenging. For the vast majority of people with OCD, the combination of ERP and cognitive therapy provides the optimum set of tools for fighting and breaking free from OCD.

MEDICATION, CBT, OR BOTH?

Now that several effective treatments for OCD are available, and increasingly so, people with OCD and their family members often ask which intervention to use, especially at the outset of treatment. In general, it's best to think of either medication or CBT as only partial treatment.

Ultimately, most people with OCD will experience the greatest benefits from a combination of medication and CBT, the former delivered by a mental health professional trained in how to use medications (usually a psychiatrist) and the latter delivered by a psychologist or therapist specifically trained in the use of CBT techniques for OCD symptoms. Both forms of treatment offer powerful benefits in the daily management of OCD symptoms. Rather than asking which treatment is better, it's more useful to ask which treatment is the most appropriate for you wherever you find yourself in the treatment process. Each approach offers unique advantages, and also has its drawbacks.

For people with the most severe cases OCD who have never been diagnosed or treated by a qualified professional, it is usually most appropriate to begin with medication. The power of medications to rapidly reduce anxiety, relieve depressive symptoms, and improve mood, focus, and concentration can give the person a big leg up in facing the hard work of CBT. Medication can be likened to water wings, keeping a beginning swimmer afloat as he or she learns the necessary skills (CBT techniques) for swimming with confidence.

However, it often happens that people with OCD take many different medications faithfully, at the proper dose and for the prescribed length of time, yet achieve only modest results. And some people find the side effects of OCD medications so intolerable that they cannot take them at all. For these people, it will probably be important to focus on cognitive behavioral therapy, and specifically exposure and response prevention. Conversely, those who have done the hard work of exposure and response prevention but experienced only limited results are likely to find the addition of medication the key component in gaining control over their OCD symptoms. A well-trained mental health professional who is experienced in the treatment of OCD can provide the best advice as to which treatment component should be your next step in the recovery process.

TRADITIONAL PSYCHOTHERAPY

Obsessive-compulsive disorder appears to be resistant to treatment with traditional psychotherapy, or talk therapy. Decades ago, prior to our present understanding of OCD, the disorder was thought to be solely the result of life experiences, such as an unhappy upbringing, dysfunctional relationships with parents, and distorted attitudes learned in childhood, for example, in regard to cleanliness. In traditional psychotherapy, clients engage in lengthy, in-depth explorations—once or even several times per week, often over the course of many months or even years—talking about their dissatisfactions about their past that contribute to their present frustrations. In this type of psychotherapy, therapists sit patiently and listen attentively to the person, hour after hour, hoping to bring about a "talking cure." While many people with OCD derive some relief from having a trained professional listen to and understand their concerns, few report that this approach actually helps improve their OCD symptoms.

Most competent therapists of all schools of therapy acknowledge a need for a broad, multipronged approach to treating OCD. Talk therapy may be helpful in strengthening coping mechanisms for dealing with the life stresses that can exacerbate OCD symptoms. When psychotherapy focuses on obsessive perfectionism, indecisiveness, doubting, and procrastination, it may be useful in increasing compliance with medication and cognitive behavioral therapy.

NEUROSURGERY

Medication and cognitive behavioral therapy are the treatments of choice for the vast majority of people with OCD, as most will obtain at least some relief from these treatments, either alone or in combination. However, an exceedingly small number of people with extremely severe and disabling symptoms don't get any relief at all from this combined approach. These individuals may qualify for "last resort" treatment with neurosurgery. Worldwide, these delicate surgeries are available only in a few medical centers that possess the equipment and highly skilled staff to perform these procedures successfully.

Neurosurgical procedures for OCD include cingulotomy, anterior capsulotomy, subcaudate tractotomy, and limbic leukotomy. These surgeries are designed to radically disrupt, or "jam," the brain circuits that are overactive in people with OCD. Most of these procedures employ a device called a stereotactic frame to make minute surgical lesions in strategic places where these circuits run. Within the past several years, a device known as a gamma knife has been employed, which uses noninvasive radio waves to create these tiny lesions. This procedure avoids the typical complications of neurosurgeries for OCD, including infections, hemorrhage, seizures, and other complications of wound healing. In addition, it's entirely painless.

Another procedure, deep brain stimulation (DBS), is well established in the treatment of severe Parkinson's disease and shows some promise in reducing symptoms in severely disabled OCD patients who don't respond to medication and CBT. In DBS, the surgeon implants an electrode stimulator in the brain without severing brain tissue or circuitry. The device generates a tiny electrical impulse that reduces OCD symptoms by disrupting the overactive brain circuits.

While neurosurgery for OCD offers relief for some of those most severely affected, it doesn't cure OCD symptoms. Only about 39 to 45 percent of patients who receive this treatment will be considered

either much improved or symptom free (Husted and Shapira 2004). However, it can improve the effectiveness of standard treatments that didn't work before surgery. Cognitive behavioral therapy is often an important part of postoperative care, and medication may also be necessary. Improvement of symptoms is likely to be progressive rather than immediate, taking several weeks or months to fully manifest.

Who should have neurosurgery to treat OCD? It is highly unlikely that anyone reading this book will need or qualify for neurosurgery for OCD. Only people suffering with severe, chronic, disabling OCD that never seems to let up—symptoms that severely affect their functioning—would qualify. And all of the medical centers that perform these procedures require that patients exhaust *all* available treatments, delivered by experts in OCD, before undertaking neurosurgery. This includes an intensive course of cognitive behavioral therapy and adequate trials of all of the available medications (at least ten weeks each, at maximally tolerated doses). Most require that patients undergo intensive treatment for a minimum of five years before considering them as candidates for neurosurgery (Jenike 1998).

ALTERNATIVE TREATMENTS

So-called alternative treatments promoted for OCD can include homeopathic methods, acupuncture, biofeedback, and dietary supplements, to name just a few. While these methods may be useful in the treatment of many conditions, their efficacy with OCD has yet to be proven. Why try unproven, so-called alternative treatments for OCD when there are so many studies supporting medication and cognitive behavioral therapies? We can think of a few reasons. People with OCD are sometimes suspicious of traditional medical approaches. For that matter, some people—with or without OCD—have a basic philosophical objection to the use of medications, preferring "natural" treatments. And in spite of the proven effectiveness of cognitive behavioral therapy, many patients avoid it because they think it will be too difficult. It can be scary at first. Others seek out alternatives because, in spite of the availability of proven treatments, in as many as 25 percent of all OCD cases, people simply don't derive much benefit from proven treatments, for a variety of poorly understood reasons. If this is your situation, it may be tempting to turn to the promise of any alternative that offers the hope of symptom relief. Even so, it's important to make certain that any treatment you consider is backed up by legitimate research studies and proof that it works better than a placebo. As we said at the beginning of this chapter, the wrong treatment can be harmful.

MAKE WISE TREATMENT CHOICES

Some people may try unproven methods because they don't have good information about which methods have been proven effective. This leaves them vulnerable to exploitation by mental health professionals who aren't informed or, in a few cases, professionals who are simply unethical. And while the numbers of psychotherapists who are sufficiently trained in cognitive behavioral therapy are increasing, they are still relatively few in number. Cognitive behavioral therapy can be hard work for the therapist, as it often requires leaving the strict confines of the office to work with clients in the real-life environment where their symptoms occur.

It is important to find a therapist who is trained in cognitive behavioral therapy or who is at least willing to study and learn. This book can assist a therapist who doesn't specialize in OCD and help him or her act as your coach or advisor as you work through the self-directed program.

Many people with OCD spend years searching for a magical cure, searching for a cause, and blaming themselves for their illness. If you believe you have OCD, stop blaming yourself or others and take control of your illness and your life. The self-directed program in this book is a powerful first step. In part 2 of this book you will embark on a tremendous journey. While it may be the most difficult journey you've ever taken, it offers you the promise of the greatest reward you can achieve: relief from the burden of OCD symptoms.

HELP FOR FAMILY AND FRIENDS

As a family member, friend, or partner of someone with OCD, your first step is to gather accurate information about the nature of OCD, its causes, and treatment. It's important not to get stuck there, however. The next step is making well-informed treatment choices. Be supportive as your loved one explores the options. Medication decisions are not lightly made, especially for those with OCD. In fact, the very nature of OCD sometimes interferes with the decision-making process. For some people with OCD, their anxious pursuit of the "perfect" treatment decision, combined with fears of making a faulty choice or decision, may needlessly or excessively delay the start of treatment. Patients and family members who routinely go online to research medical treatments commonly become overwhelmed as they wade through the massive amount of sometimes conflicting information about OCD. The actual decision to get help—what kind and from whom—can stop even the most motivated person in his or her tracks. The decision to begin exposure and response prevention can be even more daunting because of the fears that accompany the initial steps toward recovery in this approach.

At this point in your loved one's recovery, patience is definitely a virtue for friends and family members. The process of getting to the starting gate may take much longer than you'd like. The good news is that the upcoming chapters of this book can make the process smoother and easier. Hang in there and be gentle as you help your loved one identify the best treatment option.