

to familiarize the public with OCD  
and OCD spectrum disorders, to educate and to encourage  
those affected,  
and to promote understanding among their families,  
colleagues, and friends



## Unhappy? Self-Critical? Maybe You're Just a Perfectionist



by Benedict Carey  
*nytimes.com*

December 4, 2007

courtesy of Paul Stetler, G.O.A.L. Group Member

**Just about** any sports movie, airport paperback, or motivational tape delivers a few boilerplate rules for success. Believe in yourself. Don't take no for an answer. Never quit. Don't accept second best. Above all, be true to yourself.

It's hard to argue with those maxims. They seem self-evident—if not written into the Constitution, then at least part of the cultural water supply that irrigates everything from halftime speeches to corporate lectures to SAT coaching classes.

Yet several recent studies stand as a warning against taking the platitudes of achievement too seriously. The new research focuses on a familiar type, perfectionists, who panic or blow a fuse when things don't turn out just so. The findings not only confirm that such purists are often at risk for mental distress—as Freud, Alfred Adler, and countless exasperated parents have long predicted—but also suggest that perfectionism is a valuable lens through which to understand a variety of seemingly unrelated mental difficulties, from depression to compulsive behavior to addiction.

Some researchers divide perfectionists into three types, based on answers to standardized questionnaires: self-oriented strivers who struggle to live up to their high standards and appear to be at risk of self-critical depression; outwardly focused zealots who expect perfection from others, often ruining relationships; and those desperate to live up to an ideal they're convinced others expect of them, a risk factor for suicidal thinking and eating disorders.

"It's natural for people to want to be perfect in a few things, say in their job—being a good editor or surgeon depends on not making mistakes," said Gordon L. Flett, a psychology professor at York University and an author of many of the studies. "It's when it generalizes to other areas of life, home life, appearance, hobbies, that you begin to see real problems."

Unlike people given psychiatric labels, however, perfectionists neither battle stigma nor consider themselves to be somehow

dysfunctional. On the contrary, said Alice Provost, an employee-assistance counselor at the University of California, Davis, who recently ran group therapy for staff members struggling with perfectionist impulses. "They're very proud of it," she said. "And the culture highly values and reinforces their attitudes."

Consider a recent study by psychologists at Curtin University of Technology in Australia, who found that the level of "all or nothing" thinking predicted how well perfectionists navigated their lives. The researchers had 252 participants fill out questionnaires rating their level of agreement with 16 statements like "I think of myself as either in control or out of control" and "I either get on very well with people or not at all."

The more strongly participants in the study thought in this either-or fashion, the more likely they were to display the kind of extreme perfectionism that can lead to mental-health problems.

In short, these are people who not only swallow many of the maxims for success but take them as absolutes. At some level they know that it's possible to succeed after falling short (build on your mistakes: another boilerplate rule). The trouble is that falling short still reeks of mediocrity; for them, to say otherwise is to spin the result. Never accept second best. Always be true to yourself.

The burden of perfectionist expectations is all too familiar to anyone who has struggled to kick a bad habit. Break down just once—have one smoke, one single drink—and at best it's a "slip." At worst it's a relapse, and more often it's a fall off the wagon: failure. And if you've already fallen, well, you may as well pour yourself two or three more.

This is why experts have long debated the wisdom of insisting on abstinence as necessary in treating substance abuse. Most rehab clinics are based on this principle: either you're clean or you're not; there's no safe level of use. This approach has unquestionably worked for millions of addicts, but if the studies of perfectionists are any guide it has undermined the efforts of many others.

Ms. Provost said those in her program at U.C. Davis often displayed symptoms of obsessive-compulsive disorder—another risk for perfectionists. They couldn't bear a messy desk. They found it nearly impossible to leave a job half-done, to do the next day. Some put in ludicrously long hours redoing tasks, chasing an ideal only they could see.

As an experiment, Ms. Provost had members of the group slack off on purpose, against their every instinct. "This was mostly in the context of work," she said, "and they seem like small things because what some of them considered failure was what most people would consider no big deal." Leave work on time. Don't arrive early. Take

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**THE  
GIRL  
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*by  
an  
anonymous  
member  
of  
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Support  
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**Anything above zero is good.** I remembered this assertion at GOAL group recently, when Jon's discussion question was about the value of play in dealing with OCD. When a previous therapist asked me what I did for fun, I thought it was a joke. Was this therapist nuts? She honestly believed that any pleasure or enjoyment that registered above zero was a good thing. My first reaction was "Why is she asking me this? This is irrelevant to getting better. I'm in pain, and she's asking me about fun? And my second reaction was, "I don't do anything for fun."

My longing and desire to experience life was still alive, but mummified within layers of OCD thinking. I have an early memory of being 5 years old and walking with my father on a beautiful day in my red sweater and being overcome with the joy of being alive—I told my father I loved being alive, and he looked at me with no comprehension. The spark was doused in that look of indifference, and I assumed there was something wrong with me, rather than realizing he was disconnected from the world in what now we might call Asperger's syndrome, that he couldn't understand my joy and it wasn't my fault.

By high school I was keenly aware of my "deficiencies" in enjoying life. My obsessing would get worse during concerts or vacations or anything I was looking forward to. I dreaded the onslaught of fears about body symptoms, and the incessant questioning, "Am I enjoying this concert enough? What is wrong with me that my mind wanders? I must be defective for not being able to extract 100% enjoyment from this experience. I am contaminating the experience by obsessing. How can I undo this? I am obligated to attend to this concert perfectly and I am screwing up again. Why can't I just let go of my worries? I know they are irrational." Vacations were particularly grueling, being outside of my usual safety zone—what if I got sick and needed to see a doctor? What if being on vacation brings on illness? Too much free time and my mind would latch onto body sensations. And my belief that too much pleasure leads to something bad happening compounded the distress, as did my belief that I was fundamentally bad in my inability to enjoy the pleasures I didn't even deserve to have in the first place. Try and figure that one out!

This assertion of "anything above zero is good" ran smack into my OCD, and the world I lived in. But my true self was eager for resurrection, eager to be more than her thoughts, more than her distressing beliefs. My life until age 33 was mostly about being perfect, being good, and proving my worth. Any preferences I had were irrelevant. I had thrown myself into writing poetry, because my father approved of this and I was good at it, or at least that's what others told me, and I had this fear if I didn't get a book published I would vanish from the face of the earth. A couple of years into therapy I realized that writing poetry repulsed me. What an unfamiliar sensation! A preference rising up through the layers of constriction!

Before I even knew what exposure therapy was, I was doing it when I stopped writing poetry. This was my identity, my key to self-worth, and I was purposely walking away from this into my anxiety that I would cease to exist. I believed that my poems had to be perfect, so I didn't actually get a lot of writing done in spite of building my identity around it, and to consciously cease writing rather than putting my life on hold in a state of avoidance was scary.

But I went on to explore visual art, something I truly enjoyed, and that exuberant girl in the red sweater from so long ago, was still within me, and I persisted in tolerating the fear that pleasure would invoke punishment from God. Now I have set up an online shop and sell my artwork at craft shows. I never imagined I could do this! The OCD attaches to my art and I still go into avoidance and freezing as I try to find the "just right feeling" about how to proceed with making art, but I've tasted enough freedom that I have a hunger for more. Jon said the purpose of treatment is to enjoy life—who wants to get better from OCD and then have a life that sucks? ¶

# Rapid Effects of Intensive Therapy Seen in Brains of Patients with Obsessive-compulsive Disorder (OCD)

from [sciencedaily.com](http://sciencedaily.com)

adapted from materials provided by the University of California-San Diego  
courtesy of Paul Stetler, G.O.A.L. Group Member



(Jan. 2 2008) In

a study that may significantly advance the understanding of how cognitive-behavioral therapy affects the brain, researchers have shown that significant changes in activity in certain regions of the brain can be produced with as little as four weeks of daily therapy in patients with obsessive-

compulsive disorder (OCD). The discovery could have important clinical implications, according to principal investigator Sanjaya Saxena, M.D., Director of the Obsessive-Compulsive Disorders Program at the University of California, San Diego (UCSD) School of Medicine, whose findings are published on line this week in the journal *Molecular Psychiatry*.

"The study is exciting because it tells us more about how cognitive-behavioral therapy works for OCD and shows that both robust clinical improvements and changes in brain activity occur after only four weeks of intensive treatment," said Saxena.

OCD is an anxiety disorder in which individuals have unreasonable fears or worries that they try to manage through ritualized compulsive behaviors to reduce the anxiety. For example, a patient may experience the urgent need to engage in certain rituals, such as hand-washing or repeatedly checking that the oven is off or the front door is locked.

Past studies using functional brain-imaging studies of patients with OCD have demonstrated that elevated activity along the frontal-subcortical circuits of the brain decreases in response to treatment with serotonin reuptake inhibitor (SRI) medications or cognitive-behavioral therapy. However, clinical improvement of OCD symptoms was expected to require up to 12 weeks of behavioral therapy or medication treatment, the standard treatments for OCD. Only a handful of studies have looked at how therapy affects brain function, and all previous studies had examined changes over several months of treatment.

Saxena and colleagues at the David Geffen School of Medicine at UCLA made two novel discoveries in their study of 10 OCD patients and 12 control subjects.

"First of all, we discovered significant changes in brain activity solely as the result of four weeks of intensive cognitive-behavioral therapy," said Saxena. "Secondly, these changes were different than those seen in past studies after a standard 12-week therapeutic approach using SRI medications or weekly behavioral therapy."

The researchers obtained positron emission tomography (PET) scans of the ten OCD patients both before and after they received four weeks of a therapy known as "exposure and response-prevention," which gradually desensitizes patients to things that provoke obsessional fears or worries.

"This is the primary kind of therapy used for OCD. It teaches patients to pay attention to their internal experiences and tolerate scary thoughts without having to act on them," said Saxena. "They learn that nothing terrible happens if they refrain from their usual compulsive behaviors."

The normal control subjects received no treatment and were scanned twice, several weeks apart, and metabolic changes in the brain were compared between the two groups. After four weeks of therapy and without any changes in medication, the OCD patients showed significant improvements in OCD symptoms, depression, anxiety, and overall functioning.

The PET scans of OCD patients demonstrated significant decreases in glucose metabolism—a measure of brain cell activity—in the right and left thalamus after treatment. These are areas of the brain involved in OCD and where changes have been seen in numerous past studies after longer-term treatment.

However, the PET scans in this study also showed a significant increase in activity in an area of the brain called the right dorsal anterior cingulate cortex, a region involved in reappraisal and suppression of negative emotions. Increasing activity in this region corresponded to the OCD patients' improvement in clinical symptoms after the four-week course of intensive therapy. Activity in this area had previously been found to increase after cognitive-behavioral therapy for major depression. Therefore, the researchers theorize that response to cognitive-behavioral therapy across a variety of disorders may require activation of the dorsal anterior cingulate cortex, according to Saxena.

*Additional contributors to this study include E. Gorbis, J. O'Neill, S.K. Baker, K.M. Maidment, S. Chang, A.L. Brody, J.M. Schwartz and E.D. London, Department of Psychiatry and Biobehavioral Sciences, UCLA; M.A. Mandelkern of the Veterans Affairs Greater Los Angeles Healthcare System, and N. Salamon, Department of Radiology, UCLA. The study was funded in part by a grant from the National Institute for Mental Health. II*

## THE INVENTOR OF THAT SCARY DEVICE

from [thomascrapper.co.uk](http://thomascrapper.co.uk)

**Thomas Crapper** was born in Yorkshire in 1836, into a family of modest means. At 14 years of age he was apprenticed to a master plumber in Chelsea, London. After serving his apprenticeship and then working as a journeyman, he set up in his own right in 1861 as a plumber in Robert Street, Chelsea. Subsequently in 1866 he transferred his business to Marlboro' Works, in nearby Marlborough Road. He quickly gained a fine reputation for quality and service; the company expanded and by 1907 had established a flagship store on the King's Road, opposite Royal Avenue.

It is popularly thought that Mr. Crapper invented the water closet and that the vulgar word for faeces is a derivative of his name, but neither of these beliefs has been proven. Many etymologists however, do attest that the American word "crapper" for the water closet can be directly attributed to his fame. It is certainly true that he relentlessly promoted sanitary fittings to a somewhat dirty and skeptical world and championed the 'water-waste-preventing cistern syphon' in particular. Indeed, the expansion into the Kings Road shop, on one of the most important roads in London, was a bold step which brought sanitaryware out in the open for all to see. This caused quite a stir and it is said that ladies observing the china bowls in the windows became faint at this shocking sight!

Mr. Crapper's inventiveness was well known; he registered a number of patents, one for example being the "Disconnecting Trap" which became an essential underground drains fitting for domestic properties. This was a great leap forward in the campaign against disease.

By the 1880's, Crapper & Co.'s reputation was such that he was invited to supply plumbing and ware to Edward VII (when Prince of Wales) at Sandringham and some of the drainage for Westminster Abbey. Both sites still possess Crapper products; the Crapper manhole covers in the Abbey are popular for brass rubbings! Crapper & Co. remained by Royal Appointment to Edward when he became king and was also warranted by George V, as prince of Wales and again as king.

Thomas Crapper died in 1910 . . . . The company continued under the guidance of his old partner Robert M. Wharam, his son Robert G. Wharam, and Mr. Crapper's nephew George Crapper. However, by the late 1950s it was evident to Robert G. Wharam that with no Crappers or Wharams left to run the business, the sale of the company was becoming inevitable. In addition, perhaps people cared little for quality and tradition during that period. In 1963 came the end of an era—the sale to a rival firm—and by 1966 T.C. and Co. Ltd. had ceased trading as a separate company.

Since then this distinguished firm endured fallow years—but has survived—and is now an independant company once again. Having held four royal warrants and having existed through five reigns over 139 years, Thomas Crapper & Co. is once again manufacturing the finest bathroom fittings.

# WHAT IS 'INTERNET ADDICTION' AND WHAT IS ITS TREATMENT?

from sciencedaily.com,  
adapted from materials provided by Tel Aviv University  
Aug. 18, 2007  
courtesy of Paul Stetler, G.O.A.L. Group Member



**Is your first craving** in the morning for your computer mouse?  
Do you obsessively check email in the middle of the night?

If so, you may be among the ten percent of all Internet surfers afflicted with "Internet addiction disorder," a pathological condition that can lead to anxiety and severe depression. To better diagnose and treat Internet addiction, Dr. Pinhas Dannon, a psychiatrist from Tel Aviv University's Sackler Faculty of Medicine, recommends that it be grouped with other extreme addictive disorders such as gambling, sex addiction, and kleptomania.

A senior lecturer at Tel Aviv University, Dr. Dannon is known worldwide for work in the area of gambling and addiction, a major research focus for him since 1995. His first article on kleptomania was published in 1996. He will present his new research findings on addiction at the National Gambling Council's meeting in Las Vegas this November.

Internet addiction is currently classified by mental health professionals as an Obsessive-Compulsive Disorder (OCD), a mild to severe mental health condition that results in an urge to engage in ritualistic thoughts and behavior, such as excessive handwashing or, in the case of the Internet, Web surfing. "But we are saying that we need to look at Internet addiction differently," reports Dr. Dannon on behalf of his colleagues from Tel Aviv University and the Be'er Ya'acov Mental Health Center. "Internet addiction is not manifesting itself as an 'urge.' It's more than that. It's a deep 'craving.' And if we don't make the change in the way we classify Internet addiction, we won't be able to treat it in the proper way."

Two groups are at greatest risk from Internet addiction disorder, Dr. Dannon warns. The first are teenagers. But more surprisingly, the second are women and men in their mid-50s suffering from the loneliness of an "empty nest." The symptoms of Internet addiction in both groups are vague and are often difficult to diagnose. Sufferers may experience loss of sleep, anxiety when not online, isolation from family and peer groups, loss of work, and periods of deep depression.

Treating Internet addiction can only be done effectively, believes Dr. Dannon, if the condition is treated like any other extreme and menacing addiction. For example, a clinician could use talk therapy or prescribe medication such as Serotonin blockers and Naltrexone, which are also effective against kleptomania and pathological gambling. No less important, Dr. Dannon stresses, is that mental health practitioners in schools and workplaces should be made aware of the risks of Internet addiction. Workshops on these risks should be held in both milieus, he advises.

Dr. Dannon and his colleagues have recently reported their findings in the *Journal of Clinical Psychopharmacology* and have since waged a mini-campaign around the world to warn doctors about the dangers associated with excessive Internet use. Their research on gambling addiction has been used to educate American doctors taking the annual "Continuing Medical Education" test taken before the doctors can renew a license to practice medicine.

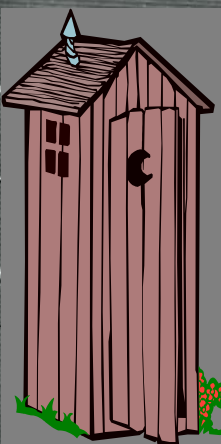
According to Dr. Dannon, Internet addicts are inevitable and a product of modernization. "They are just like anyone else who is addicted to coffee, exercise, or talking on their cellular phone. As the times change, so do our addictions." ¶



**I know how you all feel**, but in a different way.

It's like you can't believe anything you tell yourself because you might be wrong. Like just the thought or act of doing something wrong is such a big deal. But to me it is. I'm constantly obsessing if I said or did something WRONG. I might say something to someone and the minute I say it I worry that I might have said it in the wrong tone of voice or maybe I sounded stupid while I said it. So then I have to go back and try to explain to them what I really meant so I won't hurt their feelings and look stupid to them. Because sometimes I think I grew up thinking that everything was a big deal. Don't talk to loud or talk too much about yourself because it is wrong to do those things.

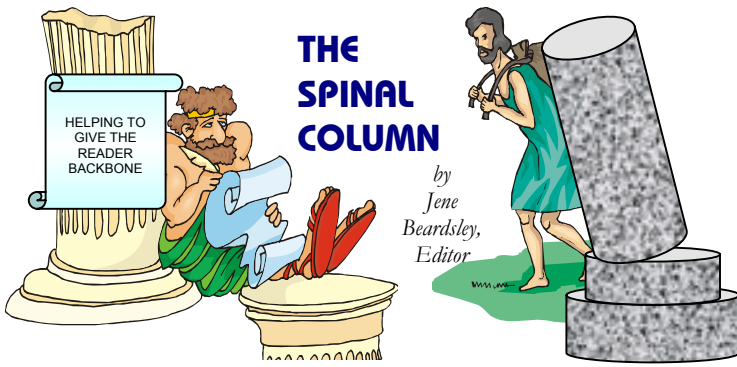
And being wrong is terrible. I feel like running through the streets saying "I'm wrong all the time so sue me and lock me up." I also obsess if I said what I say to my daughter every time I talk to her is in the right tone of voice or if I am giving her the "right" advice about things. I feel very anxious most of the time because I am afraid I will screw her up. I try to rationalize to myself that there aren't directions to life so I can relax, but then another thought asks "But there are directions to some things." I have this ongoing argument with myself all the time trying to come to a conclusion about things so I won't have any more questions and then I will know it all so I will be at peace. I have a hard time accepting that there are no absolute answers to things. I also have to make sure I speak to my mom and dad every day or kiss them every day because in case they died I won't feel guilty for not having done that. But then I am always wondering if I talked to them enough that day. And what is "enough"? Someone tell me so I'll know so I won't be wrong and won't feel guilty. Everyone says "just do your best" and the thought goes "well, how do I do my best?" as if there are specific directions for doing your best." How do you ever convince that questioning part of you that no one in the entire world knows what they are doing and that it just doesn't matter. And then I think "well what does matter?" I feel like I'm nuts. But I think I'm just very afraid of screwing up. I have this conversation with myself every day while putting on makeup. "Why am I putting on this make-up? Is it because I think I'm ugly and I'm trying to hide myself? So I sit there and obsess whether or not to put this makeup on because if I did I would be afraid of betraying myself because wearing makeup just proves that you don't like yourself and not liking yourself is wrong. So I try to rationalize that I need to look decent for work and then again argue with myself that you can look decent without it. Sometimes I wish everyone could just walk around with no teeth and look like crap and no one would care. I know sometimes I think of suicide from this nonsense but then I am afraid I would go to hell and have this go on for eternity whereas if I die on God's time frame I might go to heaven and find peace. Also I'm afraid if I killed myself I'd really screw up my daughter and I could never take the chance of doing that. So some fear is good. It's sometimes good that I can't make a decision! I pray for everyone in the whole world every day that have these types of problems and more. This problem has made me a very compassionate person and I feel you can never judge anyone for anything because you don't know what they are going through. ¶



## OUTHOUSE SYMBOLS

(source: the online Outhouses of America Tour)

Have you ever wondered why outhouses have a quarter-moon cut in the upper half of their doors as a vent? Beginning far back in time, the moon was a symbol of the female and the sun a symbol of the male. A quarter-moon was used to designate the outhouses for women and a sunburst the outhouses for men as most people were illiterate. Men were more slovenly and did not take the time to keep up the male outhouses as the women kept up theirs. With time the male outhouses fell into disrepair and became unusable and men began using the female ones which stood longer because of the care the women gave them. Soon only quarter-moon outhouses were built.



## THE SPINAL COLUMN

by  
Jene  
Beardsley,  
Editor

### BALLAST IN WONDERLAND

*Be patient toward all that is unsolved in your heart  
and try to love the questions themselves.*

—Rainer Maria Rilke

**Did I leave the iron on** before I went out to dinner tonight? Did I lock the cellar door before going to bed? Does that pond of streetwater I just drove through have sewerage in it? Was that look on my boss's face disapproval? Is something going on in the "back rooms" to bring about my dismissal? Was that paragraph in my last term paper reworded enough from its source so that it isn't plagiarism? Did I check to make sure my baby's crib is far enough away from the space heater? Was the doctor telling me the whole truth about my blood test this morning? What were those phone calls that I was afraid to answer all this week? Did I report all my last year's income on the state and federal tax forms that I mailed this afternoon? I caught twice my neighbor staring over the fence today—is she going to report me for the hoarded junk that has spilled out of my house into my back yard? Were those chocolate sprinkles in my silverware drawer really mouse dirt? Was that a pothole I hit near the elementary school yesterday or was it a child I ran over? Are people making fun of me behind my back because I wear a hat indoors?

The obsessive-compulsive chronically wonders about this and that and sends his mind and body into distressful rituals to staunch the oppressive flow of wondering.

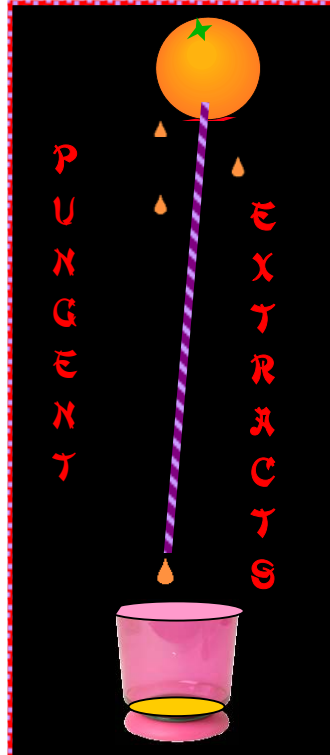
But coming from the same Anglo-Saxon root, there are two meanings of the word *wonder* and they can work *against* each other for ill or work *with* each other for good.

One meaning, usually expressed as a verb, is to doubt or to be uncertain. The other, usually expressed as a noun, refers to something surprisingly awesome or admirable.

These two meanings can work against each other in the sense that the obsessive-compulsive life can become so drained into wondering about the electric iron, the streetwater, the doctor's look, etc., that it loses awareness of the stimulating enigma that is both in us and around us and it can become so secured by rituals against uncertainty that it is suffocatingly safe, too safe to breathe in the wonder of this world and the wonder of having been born into it.

On the other hand, however, this first meaning of wonder can become an enriching part of the second. That is, the very uncertainty the obsessive-compulsive dreads can be dealt with in such a way that it actually becomes an enhancement of wonder in the sense of the interesting mystery of life. This can happen only if the unknowableness of things—and I mean here unknowableness

by the obsessive-compulsive's hopeless standard of foolproof knowledge—is accepted as part of life's normal environment—and as an enriching and stimulating part of it at that because it keeps us from the boredom of answers and summons us to look into things and therefore makes life interesting by giving it an unfailing sense of purpose. This change of attitude toward uncertainty is exactly what cognitive and exposure and response-prevention therapy aims to bring about. It is the ballast that keeps wondering from flying out of control beyond the earth's true atmosphere. ¶



The income tax has made more liars out of the American people than golf has. —**Will Rogers**

Sometimes the only intelligent thing intelligence can do in the face of stupidity is to remain silent. —**Anonymous**

Teachers open the door. You enter by yourself. —**Chinese Proverb**

Technology is a way of organizing the universe so that man doesn't have to experience it. —**Max Frisch**

For a list of all the ways technology has failed to improve the quality of life, please press three. —**Alice Kahn**

All television is children's television. —**Richard P. Adler**

Don't you wish there was a knob on the TV to turn up the intelligence? There's one marked 'Brightness,' but it doesn't work. —**Gallagher**

Television enables you to be entertained in your home by people you wouldn't have in your home. —**David Frost**

The one function TV news performs very well is that when there is no news we give it to you with the same emphasis as if there were. —**David Brinkley**

Television is more interesting than people. If it were not, we would have people standing in the corners of our rooms. —**Alan Corenk**

It is difficult to produce a television documentary that is both incisive and probing when every twelve minutes one is interrupted by twelve dancing rabbits singing about toilet paper. —**Rod Serling**

Those who flee temptation generally leave a forwarding address. —**Lane Olinghouse**

The future is an opaque mirror. Anyone who tries to look into it sees nothing but the dim outlines of an old and worried face. —**Jim Bishop**

The future will be better tomorrow. —**Dan Quayle**

I tend to live in the past because most of my life is there. —**Herb Caen**

The great French Marshall Lyautey once asked his gardener to plant a tree. The gardener objected that the tree was slow growing and would not reach maturity for 100 years. The Marshall replied, 'In that case, there is no time to lose; plant it this afternoon!' —**John F. Kennedy**

Regret for wasted time is more wasted time. —**Mason Cooley**



# HEALING A TROUBLED MIND TAKES MORE THAN A PILL

by Charles Barber  
Washington Post  
February 10, 2008  
courtesy of Paul Stetler, G.O.A.L.  
Group Member

**Feeling depressed?** No problem, pop a pill.

That's what more and more Americans are doing these days to quell what ails their troubled souls. The use of antidepressants in the United States has exploded in the past couple of decades, and drugs such as Prozac, Paxil and Zoloft, which didn't even exist 20 years ago, are household names, almost household staples.

And why not? The television ads make it seem so easy: an agonized man or woman stares listlessly into space or slumps on a bed or couch, holding their head in their hands. Then they take a pill and suddenly morph into a happily engaged and joyous being, back on the job or walking in a park, awash in sunshine, surrounded by grandchildren, a golden retriever nipping at their heels, while lush music plays in the background.

But recovering from mental illness is rarely that simple. I know.

As an optimistic 18-year-old freshman at Harvard in the 1980s, I found myself afflicted by indescribably disturbing and intrusive thoughts that involved repetitious words and irrational fears that I had harmed others. This assault on my mind—diagnosed a few years later as obsessive-compulsive disorder—led me to drop out of two colleges in as many years and made it difficult to hold down a job as a busboy.

That was the low point. After that, I began the long, arduous and at times confused process of emotional recovery. Medication was helpful—as was cognitive-behavioral therapy, particularly early on—but what ultimately made the difference, what really made me want to get well, was finding a sense of purpose in my new life, a life that had been reconfigured by illness.

The critical moment in my own recovery was my decision—very unpopular at the time—to work full-time in a group home for people with severe developmental disabilities, young men my age who could not talk. Having been given all the choices, I gravitated toward a place where there were few options. But I intuitively sensed that I would find a new path there. Indeed, I found I was good at the work, and it was therapeutic for me to "get out of my own head" and serve others.

Ultimately I returned to college, went to graduate school, and have spent my career writing about and working with people with serious mental illness in shelters, prisons and halfway houses. Both my work with my clients and my own prolonged and difficult yet ultimately rewarding journey have taught me lessons about

what's involved in overcoming true psychological distress—and what isn't.

In 2006, an astonishing 227 million prescriptions for antidepressants were dispensed in the United States—up 30 million from 2002. Altogether the United States accounts for about two-thirds of the global market for antidepressants. Other proven and practical approaches to managing milder forms of depression, such as diet changes, exercise, or cognitive-behavioral therapy, haven't gotten the attention they deserve in our high-tech zeal for the drugs.

Antidepressants can be highly effective, particularly for the more severe forms of depression. But when you speak to people with severe mental illness who have gotten better, you learn about the reality of the recovery process, which is rarely about a pill—even if that pill is effective. When you interview patients about how they got better, they hardly ever cite Prozac or Zyprexa, or lithium. For that matter, they rarely cite a particular doctor or therapist or treatment program. Rather, they talk about a person who was kind to them when they were really down; they talk about the child they wanted to be a good parent to; they talk about God and spirituality; they talk about something that brought them pleasure even when they were cloaked in pain. Many of these reasons to live—the reasons to seek treatment in the first place—are highly personal and idiosyncratic, as was mine.

As I've learned, both professionally and personally, social context is critical to recovery. In other words, there's invariably a social reason to get better. This is what has been largely overlooked by the "medical model" of treatment, which proposes that you must stabilize a person with treatment (typically drugs) before they can be put back in their social roles or environment.

Larry Davidson, a Yale researcher on recovery from severe mental illness, has examined the data and found that this model is flawed, at least in the field of mental health. "In the medical model, you take a person with a mental illness, you provide treatment in the hopes of reducing symptoms, and then they're supposed to approximate some notion of normality," he told me. "Our research shows the opposite. You take a person with a mental illness, you then reduce the discrimination and stigma against them, increase their social roles and participation, which provides them a reason to get better in the first place, and then you provide treatment and support. The issue is not so much making them normal but helping them get their lives back."

Davidson's contention is supported by the provocative finding by a number of researchers that schizophrenia outcomes are better in developing countries, where, generally speaking, patients get more support from family and society, and where ill people are less likely to be excised from their natural communities.

Another thing patients will tell you is that recovery exists, or can exist, within the context of illness. In other words, recovery doesn't mean cure. It means living with the illness, managing it and getting better within certain limitations. "I define recovery as the development of new meaning and purpose as one grows beyond the catastrophe of mental illness," says William Anthony, director of Boston University's Center for Psychiatric Rehabilitation. "My feeling is you can have episodic symptoms and still believe and feel you're recovering. It is a matter of moving beyond the debilitating phases of the illness."

The idea that recovery doesn't usually mean the removal of all symptoms is a novel and distinctly un-American way of looking at psychiatric illness, and illness in general. The fact remains, however, that most major psychiatric illnesses are episodic but chronic. Recovery involves both coming to terms with symptoms—one hopes in the context of their gradual moderation, but that's not always the case—and finding a meaningful life in their midst.

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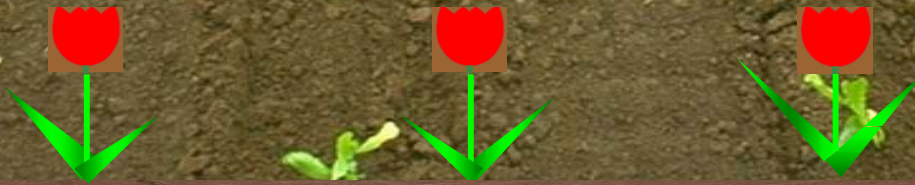
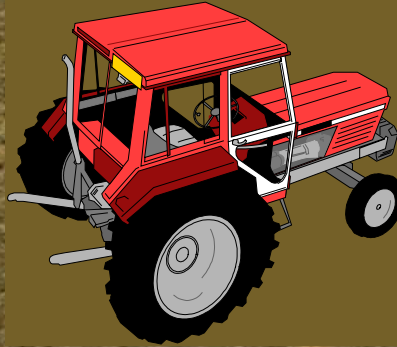
The Philadelphia Affiliate serves as a clearinghouse for information on the Obsessive-Compulsive Disorder (OCD) and provides the free professionally-assisted support groups listed here for those with the disorder.

THE TRICHOTILLOMANIA SUPPORT GROUP IS MEETING EVERY OTHER WEDNESDAY FROM 6:30 TO 7:45 PM IN SUITE 9 OF THE ROSEMONT PLAZA APARTMENTS, 1062 LANCASTER AVENUE, ROSEMONT, FOR MORE INFORMATION TELEPHONE SALLY ALLEN AT 610-525-1510.

THOSE SEEKING TO ENTER THE G.O.A.L. SUPPORT GROUP MUST FIRST CONSULT WITH THERAPIST JON GRAYSON. THIS GROUP MEETS AT 8 PM EVERY OTHER WEDNESDAY IN THE ANXIETY AND AGORAPHOBIA TREATMENT CENTER, 112 BALA AVENUE, BALA CYNWYD. THE F.O.C.U.S. FAMILY SUPPORT GROUP IS MEETING IN THE CENTER AT THE SAME TIME. FOR MORE INFORMATION ON THE G.O.A.L. GROUP TELEPHONE THERESA COHEN AT 215-676-3238. FOR MORE INFORMATION ON THE F.O.C.U.S. GROUP TELEPHONE SALLY ALLEN AT 610-525-1510

MEETINGS OF THE G.O.A.L. GROUP  
 SPRING 2008  
**March 26**  
**April 9, 23**  
**May 7, 21**  
**June 4, 18**

A SUPPORT GROUP FOR YOUNG PEOPLE IS MEETING EVERY OTHER THURSDAY FROM 7 TO 8 PM IN SUITE 9 OF THE ROSEMONT PLAZA APARTMENTS, 1062 LANCASTER AVENUE, ROSEMONT. FOR MORE INFORMATION TELEPHONE JUDY KOLMAN AT 610-525-1510.



SERIES: MENTAL LOOP, COPYRIGHT 2008  
 ARTIST: MR. PRINCE ANTHONY THOMAS

AND THEN THE FEAR RETURNS AGAIN, A FEAR OF NOT KNOWING WHAT COULD HAPPEN; WHAT IF SOMETHING BAD HAPPENS?  
 LOOP

WHAT IF I RUN OVER A DOG? WHAT IF I INJURE A PASSENGER?; WHAT IF I HAVE A BRIEF MOMENT OF INSANITY AND INJURE PURPOSELY A DOG OR PASSENGER?  
 LOOP

MY THERAPIST SAYS, "THESE "WHAT IF'S" ARE COMMON FEARS AMONG MANY MOTORISTS, BUT THEY ACCEPT THE RISKS AND UNCERTAINTIES IN ORDER TO "KEEP ON MOTORING"; AFTER REFLECTING ON THIS, MY ANXIETY DIFFUSES UNTIL I WORRY ABOUT THE NEXT PANIC ATTACK.  
 LOOP

AND THEN THE FEAR RETURNS AGAIN, A FEAR OF NOT KNOWING WHAT COULD HAPPEN; WHAT IF SOMETHING BAD HAPPENS?  
 LOOP

# Beating OCD: When Your Medication Isn't Doing Enough

## Augmentation Strategies for People taking SRIs

by Monnica Williams, PhD

### OCD is a Serious Illness

(OCD) can be a severe and disabling illness. According to a World Health Organization study, OCD is the tenth leading cause of disability worldwide, with a total cost in the US estimated at more than \$8 billion annually. People with OCD usually spend years suffering before beginning effective treatment. The situation is complicated by the fact that many health professionals are not educated about the best treatments available to OCD patients.

### Common Medications for OCD

The first-line treatment for obsessive-compulsive disorder is typically a course of anti-depressant medications, specifically serotonin reuptake inhibitors (SRIs). This term encompasses the well-known "selective" serotonin reuptake inhibitors (SSRIs), which include fluoxetine (Prozac), fluvoxamine (Luvox), sertraline (Zoloft), paroxetine (Paxil), citalopram (Celexa) and escitalopram (Lexapro), as well as the older tricyclic medication clomipramine (Anafranil). Dosages for the anti-obsessional qualities are often higher than typically needed for anti-depressant effects. The table below illustrates what is generally considered an adequate dose for OCD based on the current literature. However, some individuals respond with lower doses and others require even higher doses. SSRIs are very safe medications for most people, which is one reason physicians are quick to prescribe these to patients with OCD symptoms. However, there have been recent concerns with using SSRIs among children and teenagers, as there may be increased incidence of suicidal thoughts among depressed youths.

TABLE: Common SRI Medications for OCD

Medication (Brand Name)	Adequate Dose for OCD
Fluoxetine (Prozac)	60 mg
Setraline (Zoloft)	200 mg
Paroxetine (Paxil)	60 mg
Paroxetine (Paxil CR)*	75 mg
Fluvoxamine (Luvox)	250 mg
Citalopram (Celexa)*	60 mg
Escitalopram (Lexipro)*	30 mg
Clomipramine (Anafranil)	225 mg

\*Has not been approved by the FDA for use as an anti-obsessional drug in OCD, though frequently prescribed "off-label" for this purpose.

Though most people who try SRIs will be "treatment responders," research has shown that actual symptom reduction tends to be modest at best. Having a response to medication is not a complete cure, merely an indication that the treatment has reduced OCD symptoms by some measurable degree. Although there are reports of dramatic improvements from SRIs alone, on average people with OCD will experience only about a 30% reduction in symptoms.

Historically, people who tried one medication without success would then be switched to a different SRI until an effective one could be found. However, the use of this strategy is not well-supported by the current research. Considering the long period SRIs may take to be effective, often 4-8 weeks, the waiting and switching process can be frustrating to patients, and partial responders to one SRI are vulnerable to similar problems with other SRIs. For this reason it is increasingly common

to augment SRI medication, either with a type of psychotherapy specifically for OCD or an "add-on" medication.

### Augmenting Your SRI with Cognitive-Behavioral Therapy

Augmenting medication with cognitive-behavioral therapy (CBT) may be an especially good choice, as 80-90% of patients treated with drugs alone will relapse after they stop medication. CBT is a term used to describe evidence-based treatments that focus on reducing a patient's current symptoms through the application of learning theories to psychotherapy. This is not the same as therapies that focus on childhood issues, relationships, or unconscious conflicts; such "insight-oriented" strategies are not effective treatments for OCD. CBT treatments have a proven track-record of helping people with a variety of mental disorders, particularly anxiety disorders like OCD. The most effective CBT techniques include exposure and response-prevention (EX/RP; also called exposure and ritual prevention or ERP) and cognitive therapy (CT). EX/RP involves direct confrontation (exposure) to anxiety-provoking material while intentionally refraining from compulsions and is extremely effective, with CT as a recommended secondary option.

Among psychotherapeutic techniques, only EX/RP has been tested as an augmentation treatment for people taking SRIs. In one recent study, EX/RP was tested against stress management training (SMT), a treatment involving the use of relaxation techniques and problem-solving strategies, but without direct confrontation of the OCD symptoms. In this study, all patients stayed on their SRI medicine and were randomly assigned to receive one of the add-on therapies. Three-quarters of EX/RP patients responded to treatment and one-third were left with minimal OCD symptoms at the end of the 8-week treatment period. In contrast, the SMT group did not improve much. EX/RP appears to be a very effective augmentation strategy for those with SRI-resistant OCD.

### Augmenting Your SRI with Another Medication

Although EX/RP is very effective and offers lasting gains, it is not the solution for everyone. Because EX/RP requires that patients confront their fears, many people with OCD feel unable to undertake CBT, or they may begin CBT and find the treatment too distressing to complete. In addition, rural and underserved areas may not have a qualified professional available to offer CBT for OCD, or the sufferer may not have the resources to afford treatment even when available. Finally, a minority of OCD patients who have completed a course of EX/RP will remain highly symptomatic. For these reasons, other pharmacological strategies are important options.

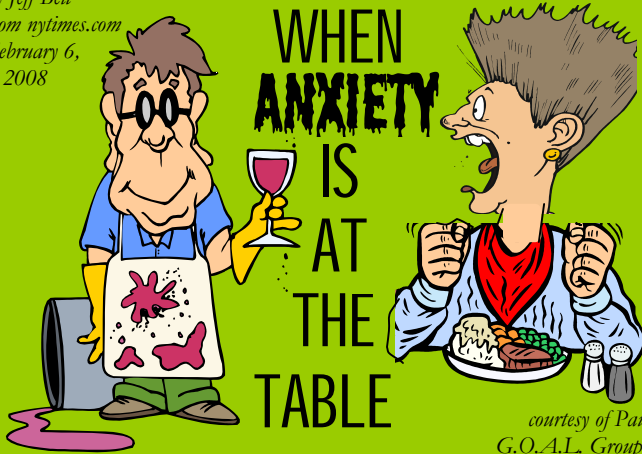
Many medications have been used to augment SRIs in people with OCD. These include benzodiazepines (i.e. muscle relaxants such as Clonazepam), mood stabilizers (e.g., lithium), tryptophan (an amino acid), inositol (vitamin B<sub>8</sub>), and others. However, the only strategy with proven efficacy in reducing OCD symptoms under the most strict research conditions makes use of a class of medications called neuroleptics, also called antipsychotics or major tranquilizers. These medications have been successful in helping people with a wide range of problems, including schizophrenia, bipolar disorder, delirium, nausea and vomiting, autism, Tourette's syndrome, and Huntington's disease, as well as OCD.

One of the first neuroleptics to be studied as an augmenter was haloperidol, but it was effective only for people with OCD who also had tics. Small doses of newer, safer medications have since been added to SRI regimens with good results. These second-generation "atypical neuroleptics" include risperidone (Risperdal), olanzapine

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by Jeff Bell  
from nytimes.com  
February 6,  
2008

## WHEN ANXIETY IS AT THE TABLE



courtesy of Paul Stetler,  
G.O.A.L. Group Member

**For some of us** the trouble starts before we even step into a restaurant.

If Carole Johnson, a retired school administrator who lives near Sacramento, Calif., happens to have a distressing thought while passing through a doorway, she needs to “clear” the thought by passing through the door twice more, doing it precisely three times.

My own challenge is fighting the urge to return to my parked car and check yet again that the parking brake is secure. If I don’t, how can I be sure my car won’t roll into something—or worse, someone?

Ms. Johnson and I are but two of the estimated five to seven million Americans battling obsessive-compulsive disorder, an anxiety disorder characterized by intrusive distressing thoughts and repetitive rituals aimed at dislodging those thoughts. We are an eclectic bunch spanning every imaginable cross-section of society, and we battle an equally eclectic mix of obsessions and compulsions. Some of us obsess about contamination, others about hurting people, and still others about symmetry. Almost all of us can find something to obsess about at a restaurant.

Sometimes the trouble is the element of public theater in the dining room, meaning we have to indulge in our often-embarrassing rituals under the eyes of so many strangers while trying not to get caught. Or it might be worrying about the safety of the food and the people who serve it.

Many of the situations that unsettle people with obsessive-compulsive disorder—driving, for instance—provoke at least some level of anxiety in just about everyone. But restaurants are designed to be calming and relaxing. That is one of the main reasons people like to eat out.

To many of us with obsessive-compulsive disorder, those pleasures are invisible. We walk into a calm and civilized dining room and see things we won’t be able to control. This feeds directly into one of the unifying themes of the disorder: an often crushing inability to handle the unknown.

“The common thread, I think, has something to do with certainty,” said Dr. Michael Jenike, medical director of the Obsessive Compulsive Disorders Institute at McLean Hospital in Belmont, Mass., which is affiliated with Harvard Medical School. “If you have O.C.D., whatever form, there seems to be some problem with being certain about things—whether they’re safe or whether they’ve been done right.”

If lack of certainty is our common challenge, than warding off uncertainty is our common quest. For some of us battling obsessive-compulsive disorder, that means scrubbing our hands to

to make sure they’re clean, or checking and re-checking everything around us in the name of safety. For others, the need is to arrange various items in order, or repeat actions in ritualized sequences in vain attempts at removing doubt.

These quirks lead to some serious complications in our lives, especially when we find ourselves in a place that triggers obsessive-compulsive behavior, like a restaurant. Once Ms. Johnson gets past the door, she often needs to try out a few tables, looking for one that feels right, as a frustrated maître d’hôtel looks on.

Personally, I am fine with just about any table, although the wobbly ones can spell big trouble. I have harm obsessions, which means I am plagued by the fear that other people will be hurt by something I do, or don’t do. Seated at a less-than-sturdy table, I conjure images of fellow diners being crushed or otherwise injured should I fail to notify the restaurant’s management. This is called a reporting compulsion in the vernacular of the disorder, and before I learned to fight these urges, many a manager heard from me.

One of them was the woman running a coffee house I frequent. One day while sipping my latte at a fake-marble table I leaned forward, and the far end of the tabletop lifted. This barely moved my coffee cup, but it sent my nerves right through the roof. Before I realized it I was crouched over, my head upside down beneath the table. The only responsible thing to do, I decided, was to ask the woman behind the counter to come over for a look. Her lack of concern only exacerbated my problems.

Forget the tabletop, my friend Matt Solomon tells me; it’s what’s on top of the table, and precisely where, that really matters. Mr. Solomon is a 39-year-old lawyer in Fort Worth with order compulsions. To enjoy a meal he needs to separate the salt and pepper shakers and, ideally, place a napkin holder or other divider midway between them.

Why? He can no more answer that than Ms. Johnson can tell you why she needs to chew her food in sets of three bites or drink her beverages three sips at a time. Three is her magic number. That is about as refined an explanation as any of us can give for our compulsions, rituals that we understand are entirely illogical.

Some of our other concerns may seem familiar. I imagine most diners, for example, have noticed and perhaps even struggled to remove white detergent spots that can sometimes be seen on silverware. But few, I suspect, have gone to the lengths Jared Kant has to get rid of them. Mr. Kant is a 24-year-old research assistant living outside of Boston who has obsessive fears of contamination. (He first came to my attention when I read a memoir he wrote about living with obsessive-compulsive disorder.) Last year he visited a Chinese restaurant with several friends, one of whom pointed out that their silverware was spotted and seemed dirty. Mr. Kant collected all the utensils at the table and attempted to sterilize them by holding them above a small flame at the center of a pu-pu platter, quickly attracting the attention of their waiter.

Ah, waiters, and waitresses. And bartenders. For some with obsessive-compulsive disorder, the success or failure of a dining experience can hinge on the appearance of a restaurant’s staff.

Mr. Solomon, for example, feels compelled to inspect the hands of anyone serving him. Cuts and scrapes are objectionable because in his mind, they can lead to his contracting a disease that could kill him.

This past Halloween, Mr. Solomon ate at the bar of a steakhouse, where he was served by a bartender dressed in a devil costume. He noticed a small red stain on the man’s right knuckle and couldn’t

*(continued on page 11, column 1)*



# The OCD Funnies



I need a paramedic. Can you send one or do I have to call someone else?

Actual call to 911, from 365 Stupidest Things ever Said

I'll take care of that, sir. Just calm down. What's the problem?

I saw a medical special on TV last night about a rare disease, and I think I have all the symptoms! My neighbor thinks I do too!

**B.Z. Toons** by Brian Zaikowski  
www.bztoons.com

Diabolical Laughter Is The Best Medicine

Mark Anderson Andertoons.com

I tried looking through rose-colored glasses, but that just made it worse!

**B.Z. Toons** by Brian Zaikowski  
www.bztoons.com

FEAR NO MORE

I have irrational fears of rear ends and rodents!

Come with me—I have just the exposure!

Diploma

What's this?!

It's the shack where Judge Judy hoards all the rat's behinds she doesn't give.

# WHEN ANXIETY IS AT THE TABLE

(continued from page 9)

rule out the possibility that the stain was blood. Trying to avoid things the bartender had touched, Mr. Solomon used a straw to drink from his water glass and swapped the silverware the bartender had placed in front of him for another set from farther down the bar.

Coincidentally, Mr. Solomon and Mr. Kant have each battled contamination issues on both sides of the counter. Mr. Solomon spent years working as a bartender, often consumed by thoughts of becoming deathly ill. He was convinced that one of his regular customers was carrying a fatal virus and came up with strategies to minimize contact. "I would always quickly put his change down before he could try to take it from my hand," he said.

The challenge for Mr. Kant was serving lattes. In his late teens, while training to be a barista, he learned of the potential dangers from improperly handled milk. He became obsessed with the possibility of harming customers through inadvertent negligence. Even worse was the prospect that he might never know. "My biggest fear was that one day I would find out that a customer had come down sick, brutally sick with something, and the only thing they knew was that they'd had a latte," Mr. Kant said.

I can't imagine handling even the most basic server duties, like adding up the items on a customer's bill. I struggle enough with checking and rechecking my tip calculations. And that's just one of my challenges at the end of a meal.

As part of my harm obsession, one of my concerns is that germs from my mouth will hurt others. Although I try to keep my fingers away from my lips and their germs while I'm eating, I'm rarely successful (it's not as easy as it sounds). By the end of the meal I believe that my hands are contaminated. The problem is that I need them to scribble my signature on the check. If I'm lucky, I will have remembered to bring my own pen; if not, I may feel compelled to "table-wash" my hands, a little trick I developed over the years: I use the condensation on the outside of a cold water glass to rinse off the germs. (Forget drying my hands, by the way; my napkin would only re-contaminate them.)

Once the check is signed, I must be sure that it is really signed. At my worst, I have opened and closed the vinyl check holder again and again, seeing my signature each time, yet unable to feel certain. I've left the table, only to return to check again. And again.

Help is available, in the form of a therapy called exposure-response prevention. As the name suggests, the technique calls for exposing people with obsessive-compulsive disorder to situations that trigger obsessions, then preventing them from acting on them. The therapy addresses low-level anxieties, and works up from there.

With restaurant cleanliness, for example, a therapist might have an client rate his anxiety about challenges ranging from simply touching spotted silverware to eating from a spotted plate. Then the therapist would ask him to face those situations while fighting the compulsion to clean or replace spotted items.

The therapy attempts to alter behavior, but it appears to alter much more than that. Dr. Sanjaya Saxena, the director of a program for obsessive-compulsive disorders at the University of California at San Diego, said that exposure response-prevention therapy "certainly is changing the brain at the molecular level—that is, at the level of particular proteins that are expressed and created

(continued on page 12, column 1)

# Beating OCD: When Your Medication Isn't Doing Enough

(continued from page 8)

"atypical" neuroleptics include risperidone (Risperdal), olanzapine (Zyprexa), and quetiapine (Seroquel). All of these medications are FDA-approved for certain uses, but are currently used off-label in the treatment of OCD. In research studies both olanzapine and quetiapine showed some positive results when compared to placebo, but risperidone demonstrated the most consistent performance across studies. Augmentation with atypical neuroleptics is now considered one of the better ways of approaching poor response to SRI treatment.

Despite the benefits and safety of augmentation, many people with OCD are reluctant to attempt this strategy for a variety of reasons. OCD patients are prone to worry, and even minor or temporary side-effects can cause premature discontinuation of potentially beneficial medication. People with contamination concerns are often uncomfortable taking any medication at all, and the idea of two drugs can be especially troubling. The older generation of antipsychotic medications, administered in higher doses, was connected to many serious side-effects, such as movement disorders, weight gain, and excessive sedation. Fortunately, second-generation medications like risperidone, taken under the careful supervision of a qualified psychiatrist, rarely result in any long-term serious problems, and often lead to major improvements in functioning.

## Maximizing Treatment Outcome

At one time OCD was regarded as an intractable disorder and no effective treatments existed. Patients lived in shame, unable to function, feeling frightened and hopeless. Today's treatments represent considerable advances beyond those early times, though many continue to suffer needlessly. SRIs bring most people with OCD some measure of relief. Augmentation with EX/RP and risperidone are good options for those who still have significant symptoms. Lack of access, lack of knowledge, and fear of new treatments keep many from experiencing the improved quality of life that may be possible for people with OCD.

There is still much research to be done, as it has not yet been determined which augmentation strategy is most effective (i.e., EX/RP or risperidone). Furthermore it is not known how to best tailor treatment based on an individual's unique symptom profile, comorbid conditions, and personal characteristics. Nevertheless, every person suffering with OCD owes it to themselves and their loved ones to persist with the existing validated strategies until they have achieved the best quality of life possible. There is no cure for the disorder, but with proper treatment and persistence many can and will beat OCD.

### About the Author:

Monnica Williams is an Assistant Professor of Psychology in Psychiatry at the Center for the Treatment and Study of Anxiety (CTSA) at the University of Pennsylvania School of Medicine, where she conducts OCD research ([www.med.upenn.edu/ctsa](http://www.med.upenn.edu/ctsa)). She also administrates the BrainPhysics OCD Mental Health website ([www.brainphysics.com](http://www.brainphysics.com)). Anyone interested in learning more about treatment for OCD, including no-cost treatment as part of research studies, is encouraged to contact Dr. Williams at 215-746-3327.

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# Unhappy? Self-Critical? *Maybe You're Just a Perfectionist* (continued from page 1)

all the breaks allowed. Leave the desk a mess. Allow yourself a set number of tries to finish a job; then turn in what you have.

"And then ask: did you get punished? Did the university continue to function? Are you happier?" Ms. Provost said. "They were surprised that yes, everything continued to function, and the things they were so worried about weren't that crucial."

The British have a saying that encourages people to show their skills while mocking the universal fear of failure: Do your worst.

If you can't tolerate your worst, at least once in a while, how true to yourself can you be? ¶

## WHEN ANXIETY IS AT THE TABLE

(continued from page 11, column 1)

and on the level of neurotransmitter function." In that sense, he said, "behavioral therapy is biological therapy."

I am no brain scientist. I understand almost nothing about proteins and neurotransmitters. But my own extensive work with this particular form of torture (that is, directed treatment), with medication, has progressively allowed me to take back much of the life my disorder stole from me.

Today I travel extensively, sharing my recovery story and working with groups like the Obsessive Compulsive Foundation to raise awareness. In my job as a radio news anchor, I don't have to eat out much, but when I'm on the road for work related to the disorder, I wind up eating in a lot of restaurants. I can honestly say I'm starting to enjoy it. In fact, while I still like ice water with my meal, I often find myself drinking from the glass, not washing with it.

Now when I say check, please, I'm simply asking for my bill. ¶

### THE G.O.A.L. POST

is looking for stories, poems, essays, questions for its professionals, and artwork. Subject matter may relate personal victories, personal defeats dealt with meaningfully, insights, strategies, sources of strength, humor, etc. Writings submitted should be literate (correct grammar, spelling, punctuation, etc.), legible (typed, preferably), and of a reasonable length. All submissions accepted for publication are subject to editorial changes and must be properly attributed to their creators, who will be identified in the newsletter unless they request otherwise. No submissions will be returned. Send your work to:

Jene Beardsley, *G.O.A.L. Post* Editor  
NEMuscoot@aol.com.

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The views expressed in the articles of this newsletter are those of their authors and do not necessarily represent the Philadelphia Affiliate.

## HEALING A TROUBLED MIND TAKES MORE THAN A PILL

(continued from page 6)

For many patients, this is a decades-long process of acceptance and resolve. At the end, some patients can actually say they're glad—within reason—that they've experienced an illness, because it has greatly enriched their lives and their appreciation of things. We do have to be careful not to romanticize suffering, but this is nonetheless something you commonly hear from those who have found the elusive meaning in the presence of sickness.

This leads us to the final lesson I've learned: treatment is most effective when the patient is in charge and the ultimate expert in his or her own recovery. There is evidence that when patients feel in control, the results of treatment are better. Treatment works best when the doctor or therapist acts as a kind of expert consultant. As Home Depot puts it: "You can do it, we can help."

That's what I found in my own process. That my journey was a self-directed path, one in which I saw myself as the author of my recovery rather than as a passive recipient of a pill, made all the difference. Ultimately I no longer saw myself as a patient but as a writer, father and husband. Ultimately I found ways to use my obsessive ways adaptively. A little like Monk, the television detective who uses his OCD to solve crimes, I repurposed or redefined my illness to write and research with extra drive.

But these complex lessons about the arduous realities of attaining emotional health, as told not by doctors or companies but by patients, have received little traction in mainstream health care and the mainstream media. The negative reception isn't surprising. Listening to patients cuts against the establishment grain. We live in an age of experts, in which we like to cede control of our bodies and our being to others. Different parts of our bodies go to different experts. The ultimate expert, perhaps, is the pill. Our fervent and simple-minded belief is that the experts, and the pills, will take care of things for us.

The simultaneously inspiring and terrifying reality is that getting better—the winding, agonizing road to stability—is a little messier (and a lot more interesting) than we would like it to be.

(Charles Barber is a lecturer in psychiatry at the Yale University School of Medicine and the author of the just-published "Comfortably Numb: How Psychiatry Is Medicating a Nation.") ¶

