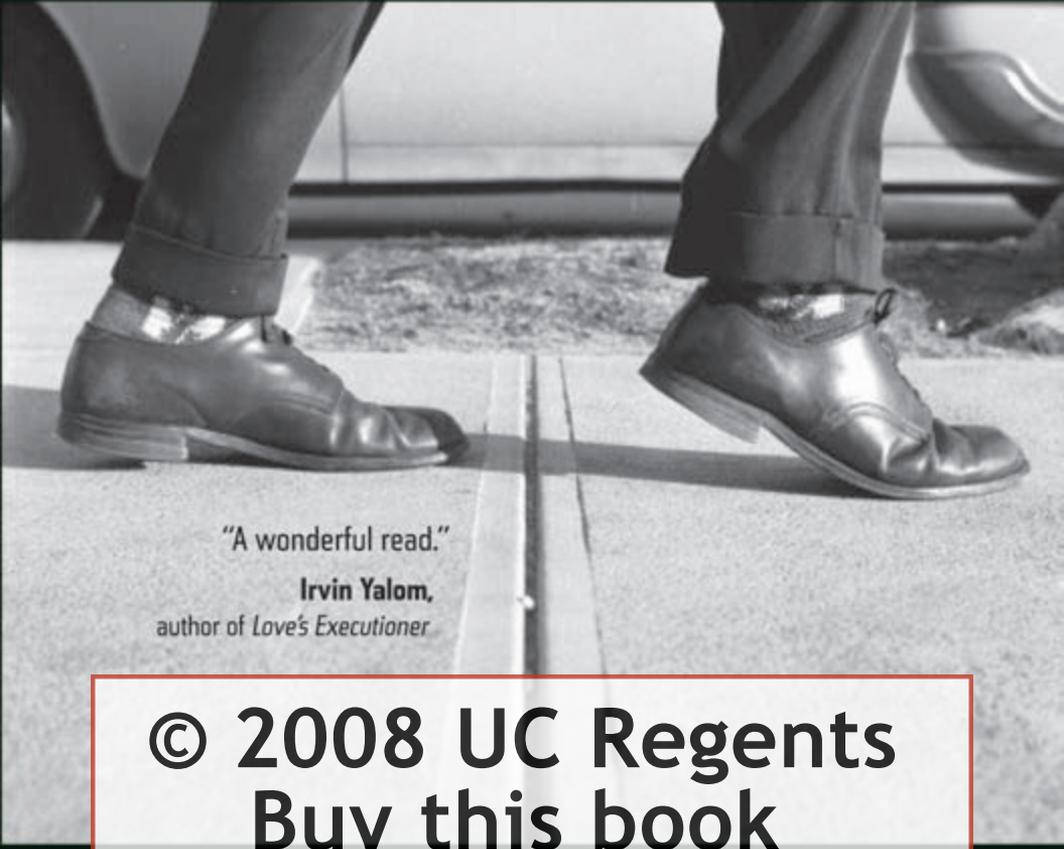


COMPULSIVE ACTS



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A Psychiatrist's Tales of Ritual and Obsession

ELIAS ABOUJAOUDE, MD

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Psychiatry by the Dumpster

George was special from day one. I can still remember Dawn, my clinic clerk, paging me at 1:45 P.M., three quarters of an hour after his first scheduled appointment, to warn me: “Oh, Dr. A., you’re gonna love this one!”

“Please don’t tell me the patient just showed up,” I said. “How am I supposed to do a full intake in the remaining fifteen minutes?”

“I know,” Dawn answered, “but I couldn’t just let him go. I don’t know what to say, but he’s—how should I put it?—he has his reasons for being late . . . He’s special, even by our standards in this clinic, and even after nine years of doing this! I had to go out into the parking lot to check him in. That should give you an idea . . .

“You went to the parking lot to check him in?” I asked. “Outside?”

“Yes, outside,” Dawn answered. “He can’t come in, he says. Our door isn’t wide enough for him.”

“Our door isn’t wide enough?” I queried, wondering whether I was the right doctor for this patient. “Did he mistake us for the gastric bypass clinic? How heavy is he?”

“Oh, he’s not heavy at all,” Dawn answered. “In fact, his wife tells me he hasn’t eaten in a few days. He’s just . . . I don’t know . . . Something about his nose . . . He won’t let anyone or anything close to it . . . He was so worried about his nose, he wouldn’t even get into the car this morning.”

“How did he make it to our clinic, then?” I asked. “I thought he lived in Belmont. That’s fifteen miles away.”

“He does,” Dawn said. “He walked here. His wife drove, but George walked.”

“He walked?” I asked in disbelief. “All the way from Belmont?”

“All the way from Belmont,” Dawn repeated. “That’s why I can’t simply send him back and ask him to reschedule. Anyway, he *is* checked in now and waiting for you over in the far corner of the parking lot, exactly three feet from the dumpster, where, I might add, his wife spotted your old, squeaky office table and asked me to help her pull it out and put it in her trunk. I’m no doctor, but she’s not right, either . . . What use could she possibly have for that table? Anyway, what would you like me to do now?”

“Well, I guess my only choice is to come right down,” I said. “Meet me by the dumpster.”

“OK, just remember not to get too close!” Dawn warned. “You might frighten him. And by the way, your two o’clock is here, too.”

“Great! Is my two o’clock at least waiting in the waiting room?” I asked.

“Yes, she is,” Dawn answered. “And I told her it was going to be a long wait . . .”



I walked toward Dawn, who was standing in the far corner of the parking lot. Nearby, in a vacant handicap spot by our recycling dumpster, stood George. In the adjacent spot, having managed with Dawn's help to squeeze my old filing cabinet into her trunk, stood his wife, now trying unsuccessfully to push the trunk door shut.

George was a lean twenty-something, with wide green eyes and a sunburned face and neck, probably from having walked a very long distance in the midday sun to come to my office. His grooming and hygiene left something to be desired, and his dirty fingernails and caked hair indicated more than just the wear and tear of one day's walkathon.

His wife started the conversation. "Dr. A., thank you for coming out here to see us," she said, still intent on shutting the trunk, despite one leg of my old office table clearly sticking out. "I know this is not standard practice, but it's very difficult to get him through doors anymore. I read up on obsessive-compulsive disorder, so I know how to diagnose it. Heck, I may even have a touch of it myself . . . We're here because we were told you were a specialist in OCD. It's urgent, Doctor! Things have gotten completely out of control since it's grown to three feet. *Three whole feet!*"

I was intrigued by the three feet but realized that I had not yet introduced myself to George. However, before I could formally do that, George preempted my handshake.

"I don't mean to be rude, Doctor," he said apologetically, "but please don't stick your hand out. I can't do handshakes."

“That’s OK, I understand,” I said. “I’m pleased to meet you anyway. Your wife just mentioned that ‘it’s grown to three feet.’ What is it that has grown to three feet, George?”

“The radius around his nose,” his wife answered, the quiver in her voice betraying her anxiety. “He needs that much clear space around his nose at all times. In the good old days, it used to be that nothing could come within a foot of his nose, and we could joke about it. But when the radius grew to two feet, it was anything but funny, and we started needing to make lifestyle modifications: having to sit alone in the backseat of the car, trying to sleep standing up like a horse, not to mention—if I may go there in your parking lot—the challenging sex . . .”

I could see Dawn’s face tense up at the idea of “going there.” The sexual comment was clearly in poor taste for her and went against deeply ingrained prohibitions on discussing private sexual matters even in clinical conversations—that is, if you can really call a parking lot discussion a “clinical conversation.” Dawn soon found an outlet for her anxiety, however: she strode over to the trunk, broke off the old table’s leg, threw it inside, and snapped the trunk closed with a satisfying thud.

The sound of the trunk shutting and the thought of securing the old cabinet for her home also dissipated George’s wife’s anxiety, and a relieved smile made its way to her face.

“But then,” she continued, more at ease, “even two feet weren’t enough. It had to grow to three feet, and at three feet, it has been, well, impossible to accommodate!”

Steering the conversation back to the principal patient, I asked, “How long has this been a problem for you, George?”

“Oh ever since . . . I don’t know . . . It sort of crept up on me,” he answered.

“Ever since his brother died,” his wife interjected.

“When did that happen?” I asked.

“Two years ago,” George answered. “He died in a skiing accident.”

“I’m very sorry to hear that,” I replied.

If sex had been difficult to discuss in the parking lot, death would have been even more so, so I asked George, “I know this is hard for you, but can you try once more to come up to my office so we can continue this important conversation in private?”

“I can’t. I’m sorry,” George answered, cautiously shaking his head. “Doorways are difficult for me. Hallways are challenging. And elevators are out of the question.”

“Nothing personal, Doctor,” George’s wife added. “His father was visiting from Europe, where he lives, last month. We hadn’t seen him in two years. Well, George wouldn’t even give him a hug! All he could do was wave hi from a safe distance when he arrived at our house and wave goodbye when we dropped him off at the airport.”

Seeing that the entire first meeting would probably have to be conducted outside, I wanted to make myself more comfortable. I went over to his wife’s car to lean against the door, moving only slightly in George’s direction. George responded briskly, stretching his arms out and twirling in a 360-degree circle, his arms fully extended. The move resembled a disc rotating on its axis; its purpose, I surmised, was to make sure the required radius of safety was not violated by my sudden movement and that I did not put his nose in any danger.

Sensing that I may have inadvertently increased George’s anxiety, I tried to give him a little break by addressing my next question to his wife.

“You said you might have a touch of OCD, too,” I said. “Tell me about it.”

“Well, it’s really just a touch,” she said. “Nothing like this! I don’t worry about injuring my nose, although I should! I broke it twice already, once in a car accident and once in a diving injury. My OCD, if we may call it that, actually makes sense . . . It’s about making sure I don’t run out of important things. ‘What if I need it one day?’ I always ask myself when I consider, or George makes me consider, throwing something out. And this simple question is usually enough to make me save the item, whatever it is. You can understand, then, how I built up my collection of pots and pans and cooking magazines and the tables I hope to stack them on. Did I mention cooking magazines? That is probably my biggest weakness!”

“Indeed,” George agreed, gently nodding his head in agreement. “She has so many cooking magazines all over the kitchen, she can’t make it to the stove to cook!” he added with a smile.

“That’s right,” his wife agreed. “I honestly can’t remember the last time I cooked a meal for this poor man.”

“But despite the mess in the kitchen,” she continued, “we still eat well—or ate well, I should say—until his symptoms began. When he was at one foot, he couldn’t use utensils, so I would buy him pizza, which he ate alone in his office. We lived on pizza for months because it didn’t require a fork and knife. I would ask him, ‘George, how come the pointy end of a pizza wedge is OK, but you can’t use a knife and fork?’ and he would say that something about metal approaching his nose was much scarier than the pointy end of the pizza wedge. Well, I thought it was kind of tragic, especially for someone who loved to eat and appreciated food so much. But oh, how I miss those days now! You see, when

the radius grew to two feet, he couldn't even eat pizza, so he started insisting on soups and fluids, served in plastic bowls without a spoon. Later, when the radius grew to three feet, he started avoiding coming home altogether. He thought it was too much of a hazard, with all my stacks of cooking magazines and other stuff strewn all over the house. He didn't want to fall and hurt his nose, he said. So now he rents a studio nearby and eats—oh, I don't know what he eats, or *if* he eats . . . Look at how thin he's gotten!"

George did appear thin, but more than his low weight, it was his disheveled appearance that marked him as unhealthy, so I asked him, "What about basic activities of daily living besides eating? Toileting and hygiene, for instance?"

"This is really embarrassing, Doctor," George answered, looking down and away from me. "I can't shower anymore. I feel the showerhead is about to attack me. We even had a plumber come in to replace it. He said he would have to install the showerhead in our neighbors' kitchen if he adhered to my specifications of how far it should be from my head when I'm standing in the tub! I know it's crazy, Doctor, but I really can't help worrying about it."

"Worrying about things that don't make sense and constantly checking to make sure one is safe are common symptoms in OCD," I said. "It doesn't mean you're crazy. It means you have OCD, and that is only a small part of who you are. The good news is that for many patients OCD is quite responsive to treatment, so I'm glad you made the decision to come here today."

It is important during a first psychiatric meeting to try to get a fuller sense of the patient than his symptoms alone, so I inquired about George's hobbies and work experience next. Unfortunately, the conversation always came back to OCD. "What do you enjoy

doing in your free time?” I asked. “Tell me more about the part of you that doesn’t have OCD.”

“Well, I used to sing in church,” George answered, “but I’ve had to give that up, too. The idea of getting a microphone close to my nose is enough to make me mute with anxiety!”

“How about work, George?” I asked.

“I used to work in a large advertising firm,” he answered. “I had to give that up, too. My cubicle got too small for my nose . . .” George smiled at the visual—an expanding nose in a shrinking cubicle—and I smiled, too, appreciating this young man’s stubborn sense of humor, still evident despite the obvious stress he was under.

But many pieces of George’s life and history were still unknown to me, and I could feel a hundred questions racing through my mind, all begging to be asked. By that point, though, I was very late for my two o’clock appointment, who was still patiently waiting for me, so I left George and his wife in the parking lot after getting their promise to return the following day so we could continue our “first meeting.”

I did not leave them alone, though. I left them with Dawn, hoping that her powers of persuasion would be sufficient to get George inside the car.

“If I can get that old oversized table into your wife’s trunk and manage to shut the door, I can get you into the car, too,” she said to George as I walked away. As I overheard her ordering George’s wife to open the sunroof, I cringed at the thought of what she might have in mind for George’s trip home . . .



We all have our peculiar habits and bizarre superstitions, but most of us don’t suffer from OCD. Obsessive-compulsive disorder, the

clinical condition, afflicts 1 to 2 percent of the population, and males and females are about equally likely to get it. For most sufferers, OCD is a chronic problem that will continue to negatively impact their lives, although the intensity of their symptoms may vary over time.

The fourth edition of the *Diagnostic and Statistical Manual*, or DSM-IV, the “bible” used by mental health professionals for diagnosing mental illness, defines OCD as the presence of obsessions *or* compulsions. To be clinically meaningful and meet DSM-IV requirements for a psychiatric diagnosis, the obsessions or compulsions must take up at least one hour daily and interfere substantially in the person’s life. The DSM-IV criteria for diagnosing OCD are listed in on page 10.

Typically, OCD includes both obsessions *and* compulsions. Obsessions are unwanted thoughts, images, or impulses that come into the patient’s mind in a repetitive way and that the patient experiences as bothersome. Common obsessions in OCD include contamination fears, such as fear of catching an infection or fear of pollution; “pathological doubt,” especially about whether safety checks at home or in the car have been performed; symmetry obsessions, like the need to preserve things in perfect order; “somatic” obsessions about particular body parts or body functions, such as unjustified worries about one’s nose or fear of fecal incontinence; and disturbing thoughts of a blasphemous or incestuous nature, as might be seen in a patient with no history of, or desire for, incestuous relationships, who has distressing mental images about having sex with a parent.

Compulsions are rituals performed by the person with OCD to neutralize the obsessions and reduce the anxiety they cause. Common compulsions include frequent checking of doors,

Diagnostic Criteria for Obsessive Compulsive Disorder

- A. The presence of either obsessions or compulsions.
Obsessions are defined by (1), (2), (3), and (4):
1. recurrent thoughts, impulses, or images that are experienced as intrusive or unacceptable;
 2. the thoughts, impulses, or images are not simply excessive worries about real-life problems;
 3. the person attempts to ignore or suppress these thoughts, impulses, or images or to neutralize them by other thoughts or actions;
 4. the person recognizes that these thoughts, impulses, or images are the product of his own mind.
- Compulsions are defined by (1) and (2):*
1. repetitive behaviors or mental acts that the person feels compelled to perform in response to an obsession or to satisfy rigid, self-imposed rules;
 2. the behaviors or mental acts aim at reducing anxiety but are not logically connected to the source of anxiety or are excessive.
- B. The person recognizes that these obsessions or compulsions are excessive or unreasonable.
- C. The obsessions or compulsions cause distress and disability, and take up more than an hour daily.
- D. The obsessions or compulsions are not better explained by another mental illness (e.g., are not limited to preoccupations with weight in a patient who has anorexia nervosa).
- E. The symptoms are not due to substance use or a medical condition.
-

Source: Adapted from the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. Washington, DC: American Psychiatric Press, 1994.

windows, stoves, car locks, or body parts; excessive cleaning, either of one's body or one's environment; hoarding of useless items in case they are needed in the future; and a need to repeatedly ask for reassurance or to confess perceived mistakes. Compulsions need not be observable behaviors and can be *mental* acts that the person performs, such as praying in rigid, preset ways, counting in silence up to a predefined number, or repeating certain words or sentences to oneself in fixed patterns "until it feels right."

Some compulsions cluster naturally with particular obsessions. For instance, excessive cleaning or hand-washing (the compulsion) often goes with contamination fears (the obsession), and frequent checking (the compulsion) often goes with pathological doubt (the obsession). Other obsession-compulsion pairs are not related in any "rational" way. For example, Sean, a pleasant young athlete I see in my clinic, experiences obsessive incestuous thoughts involving his sister. He is absolutely disgusted by these thoughts and has never had any desire or intention to act on them. For Sean, the compulsion that helps neutralize the anxiety accompanying this obsession consists of tapping his inner thigh five times every time the thought intrudes on his mind.

Of all compulsions, excessive checking is the most common and is seen in over 60 percent of people with OCD. Some checking compulsions take the form of exaggerated everyday behaviors that in normal individuals are automatically and quickly performed—examples include checking to make sure the doors are locked or that one did not accidentally hit a passerby while backing out of the driveway. A person with OCD, however, may spend several hours a day checking and rechecking, often in complex, uncompromising patterns.

The following scenario from a patient with OCD whom I treat for checking compulsions is representative. Before he can leave for work in the morning, Tim has to feel secure that the stove in his kitchen is turned off. His ritual demands that he check each knob five times, waiting sixty seconds every time with his hand on the knob to make sure it is in the “off” position. Given that his stove has four knobs, it takes Tim twenty minutes to complete this ritual before he can leave the house or, if he is going through a bad OCD period, before he can move on to other checking rituals, such as making sure the doors and windows are locked, the faucets in the bathroom are not leaking, the irrigation system in the garden is turned off, and the drains on the roof are not clogged.

Still, other checking rituals in OCD are much more unusual than Tim’s. Two patients I treated come immediately to mind: Stephanie, who had to check that her left arm was still attached to her body by holding it inside her right hand and focusing intensely on it; and Paul, who, before allowing any piece of paper to leave his house, had to meticulously read and then shred it, “on the off chance I wrote my social security number on it by mistake.”

But if their behaviors appeared bizarre to people around them, they also seemed strange to Stephanie and Paul themselves. People with OCD are usually well aware of how nonsensical their symptoms are and are often the first to describe them as “silly,” “embarrassing,” or “crazy.” In Stephanie’s case, when her husband tried to reassure her that her left arm was fine, her typical answer was, “Of course I know my left arm is fine. I’m perfectly healthy, physically. I just can’t help checking to be sure.” For Paul, when I asked him how he did not seem to worry about inadvertently writing his social security number down at work, he quickly

answered, “I honestly can’t explain why it doesn’t bother me at work. I recycle papers there all the time without thinking twice about it. I even gave away my office shredder to a coworker! This doesn’t make sense to me, either.”

Still, in the most severe OCD cases, patients may lose such rational perspective on their illness and start thinking that their obsessions and compulsions make sense and are justified. A good example is Jeff, a patient I treated for irrational fears around catching the cold virus. Jeff fully believed that turning the closest light switch on and off ten times after shaking hands with people somehow boosted his immune system and protected him from getting a cold. Such OCD cases take on an almost psychotic dimension because the patient’s reality-testing seems impaired. For that reason such a patient tends to be more difficult to treat—unfortunately, Jeff has been in therapy and on various combinations of medications for many years without any sustained improvement in his symptoms.



For our meeting the following day, George again walked from his apartment to my clinic. With much encouragement from his wife and Dawn, however, George was able to pass through the building’s doors and climb the stairs to the clinic area, after performing a checking regimen that required a whole hour to complete: with each step he took from the building’s main door to my office, George would make a 360-degree turn on his feet, his arms outstretched to clear the space around him. Dawn led his wife to the waiting room so I could meet with George privately.

Once inside my office, George used one hand to move a heavy wooden armchair from one corner of the room to the center,

using the other hand as a protective shield for his nose in case he moved the chair too close to his face. He then very cautiously sat in the chair. As he performed this ritual, I found myself rolling my chair back into the corner to give him additional security.

“Why me?” was his first question.

“I wish I had a satisfactory answer for you,” I said, “but, like so many other psychiatric and medical illnesses we see, we are much better at treating disease than at knowing exactly why a particular person develops a particular symptom.”

“Did I somehow catch it from her?” he asked, referring to his wife but appearing suspicious about the premise of his question, as though he knew beforehand that the answer would be no. “But I don’t hoard,” he quickly added. “In fact, I’m the anti-hoarder.”

“You cannot ‘catch’ OCD that way, George,” I said. “You might have a genetic vulnerability to developing OCD if you had a close blood relative with it. However, even when OCD does cluster in families, its symptoms can vary greatly among family members.”

“Well, I don’t have any biological relatives with it, as far as I know,” George quickly said.

“Speaking of catching things,” I said, “do you spend a lot of time worrying about contamination or pollution? How about frequent checking that doesn’t involve your nose? Any excessive cleaning, counting, touching, arranging, or worrying about other body parts besides your nose, now or in the past?”

“Never,” George answered. “Other than this preoccupation with my nose, I’ve always been a pretty laid-back, relaxed guy.”

“Do you worry that your nose may be weak or somehow deformed and in need of protection?” I asked. “Do you think it looks abnormal?”

“No, I think my nose looks just fine as it is now,” George replied. “I’m very happy with it. I just want to keep it that way!”

“Do you have any reason to worry that it might not stay that way?” I asked. “Are you prone to accidents, for example? Have you ever seriously injured your nose or any other body part before?”

“Not really,” George answered. “I’ve always been a cautious choirboy and high school debater kind of guy rather than the contact sports type.”

After ascertaining that it was not the memory of some old physical trauma that made George worry about hurting himself, I wondered about a trauma he might have witnessed involving someone else, or even an emotional trauma. Thinking back to our first meeting, when his wife related the onset of George’s OCD symptoms to losing his brother in a skiing accident two years ago, I said, “Tell me about your brother, George. Were you close?”

“Yes, very,” George answered, looking down and away. “I was supposed to go with him on his skiing trip, but a choir event kept me back.”

“I’m sorry to hear about what happened to him,” I said. “Is it true that your OCD symptoms began shortly thereafter?”

“As I said, it sort of crept up on me,” he answered, “but I would say sometime around then I started frequently checking my nose in the mirror to make sure it was OK.”

The striking coincidence between the onset of George’s OCD symptoms and the loss of his brother is rich in meaning and symbolism. It is relatively common for patients with OCD to experience their first symptoms or to relapse after a symptom-free period as a function of external stress. But beyond that, were George’s specific symptoms somehow determined by the nature of the stress? Could the unexpected loss of a young, healthy

brother to a fatal accident have made George overly vigilant about his own environment, in a desperate attempt to prevent a similar tragedy from happening to him?

However, before I could expand further on this hypothesis, we heard a light knock on the door. George's wife then cautiously walked in, careful not to swing the door fully open in a way that might disturb George, who was still sitting in a chair in the center of the room. She carefully deposited an oversized bag on the floor against the wall, then stood practically stuck to the wall.

"I thought I had given you enough time alone and was burning to ask you some questions about my role in George's treatment," she said. "For example, I feel sometimes like I'm colluding with him and making things worse, like when I agreed to unhinge and remove the French doors between the dining room and the living room to make the passageway safer for his nose. Should I have just said no and expected George to deal with the anxiety of navigating the doorway? Did I do more harm than good by giving in to his OCD?"

"You raise a very good question," I said. "It's a difficult balance that you're being asked to strike. On the one hand, it's a natural instinct to help your husband when he asks for it, but on the other hand, you know that giving in to his OCD can perpetuate his symptoms and allow him to avoid addressing them. In my opinion, the best way to handle this is to try to accommodate severe OCD fears that, if not allayed, would paralyze him. However, you should try to avoid giving in to lesser fears you think he can handle on his own. There's a way to do this that teaches him how to work through his anxiety and be more independent."

As I tried to explain to George's wife her role in treating her husband's OCD symptoms, I couldn't help but think of a possible

indirect role she might have played in *causing* them. From my previous conversations with George about his wife and what I witnessed in the parking lot when she rescued a useless old table from the dumpster and took it home, it was clear that George's wife also suffered from a form of OCD, which manifested itself primarily in hoarding behavior. Could her collections of useless objects and magazines cluttering the house be even more obstructive to George than the French doors in her example? Would another way to understand George's specific symptom and his need for space be as an unconscious retaliation against his wife for the hoarding that had severely cluttered their lives? By becoming so debilitated by objects that stick out and eventually having to leave the house because of it, was George signaling to his wife his distress over the state of the house and her inability to fully acknowledge her own illness and get treatment for it? A Freudian psychiatrist might read in George's symptoms—and expose to him in the course of therapy—the following unconscious message to his wife: it's time for you to give the house a cleaning, to admit that you have OCD yourself, and to do something about it.

It was, of course, a delicate dance. While I wanted to try to point out features of George's wife's behavior that might have promoted and contributed to her husband's symptoms, I could not afford to forget that George, not his wife, was my patient. It wasn't my role to diagnose or treat her, especially since she was only willing to accept that she had a "touch" of OCD. Still, I would have liked to gently explain to her the possible interplay between her "touch" of OCD and her husband's full-blown condition, but another knock on my door, followed by Dawn's entry, interrupted me.

Dawn was very careful not to swing the door fully open. Once inside, she also positioned herself against the wall, adding to the

drama of the “set.” As it now stood, the configuration of bodies and furniture in my office was as follows: George in his chair in the exact center of the room, me in mine tucked in the far corner opposite the door, George’s wife plastered against the wall on one side of the door, and Dawn adopting the same position on the other. Between the two women, also stuck to the wall, was George’s wife’s oversized bag.

“I’m not just being unreasonable because I haven’t eaten all day,” Dawn said, referring to the annual Lent fast she had just begun, “but we have a problem on our hands, and we’d better address this now.” Then, looking alternately at George’s wife and the bag on the floor, she pronounced, “You cannot do that. I saw you. You cannot take the cooking magazines from our waiting room. What’s in the dumpster outside is fair game, but not what’s inside the building! We can help you if you need help, but you cannot be taking our magazines, especially since we work hard to keep our reading material up to date compared to other clinics!”

An uncomfortable silence descended on the room, which George finally tried to break with an attempt at humor: “I guess you have kleptomania on top of hoarding, my dear,” he said, gently shaking his head and chuckling briefly.

But there was nothing humorous in any of this for his wife. Her face turned deep red, and she tried hard to avoid the other three sets of eyes in the room. Seeing how much embarrassment she had caused, Dawn quickly sought to defuse the situation: “But I promise to save any *old* issues for you if you want!”



Dawn, née Aurora, is much more to our clinic than her clerical title would suggest. Our schedule is like a symphony of which she

is the masterful conductor. She makes sure records are up to date, orders are placed before supplies run out, and unpleasant communications with insurance companies are handled with minimal doctor involvement if at all possible. But, far more than her unquestionable administrative skills, it is Dawn's unique style and her compelling story that make her so indispensable to our clinic.

Coming in for a psychiatric evaluation, especially if it's a patient's first contact with the mental health system, can be a traumatic experience. With Dawn on the front lines handling phone calls and check-ins, the patient is guaranteed to receive caring, experienced service that conveys a you-don't-need-to-worry-I've-seen-it-all-before attitude that is both blasé and oddly comforting. And on the rare occasions when she comes across as abrasive or demanding, as she did with George's wife on the couple's second appointment, the deep reserve of trust and respect that the patient, his family, and of course the doctor have for her allows us to see her behavior as a manifestation of "tough love" ultimately in the patient's and the clinic's best interest rather than as an intentional breach or an unforgivable faux pas. And so we put up with Dawn operating sometimes on the peripheries of what is sensitive or totally appropriate because we're convinced that patients will ultimately be better off for it, and the clinic will run more smoothly as a result.

But if tough love is her *modus operandi* at work, when it comes to Hector, her husband of fifteen years, Dawn is all love, all the time, without any toughness. Ever since the couple, then in their early twenties, emigrated from Mexico some twelve years ago, they have been inspiring in their commitment to each other and their pursuit of what one might still call the American dream:

happiness, self-improvement, and material comfort for themselves and their children.

In people observing Dawn and Hector's hard work and enthusiasm for their new life, they rekindle the optimistic belief in America as the land of possibilities. Years ago, for example, she decided to change her name from Aurora to Dawn to mark the English-only policy she instituted at home to help her girls learn English and fully integrate at school. More recently, Hector took what might be considered the quintessential new American job—an unpaid clerical position with a new Internet start-up company in exchange for stock options that might eventually translate into cash if the company succeeds; as a result, Dawn, now the sole breadwinner, has had to take all the overtime hours she could to supplement the family's income.

Through it all, Dawn has handled her immigrant family's struggle to enter the U.S. middle class with dignity, hope, and remarkable resilience. But on those rare days when the pressures of life combined with clinic stress get to her, Dawn can always count on one of her well-meaning, usually also foreign-born fellow clerks to lend an ear and to remind her how it could all be so much worse . . . How, for instance, one of her girls could be afflicted with severe OCD, or how she and her family could still be living in poverty in Mexico City, or both!



OCD does sometimes seem like a natural disaster visited on the unlucky. To explain why some people develop this illness, we have to borrow information from neurobiology as well as various schools of psychology. There is little debate that OCD, like many other psychiatric conditions, has biological roots. Brains of

patients with OCD actually look different when scanned, both in the overall size of certain brain regions and in the higher blood flow and metabolic activity seen. More intriguingly, successful treatment of OCD symptoms with medications or therapy seems to correct these differences so brain patterns become indistinguishable from what you see in people without OCD. Such measurable differences in parts of the OCD patient's brain point strongly to at least a partly biological explanation for the disorder.

So does what is happening at the level of the neurons, the individual brain cells that make up the brain centers. Serotonin, a neurotransmitter—that is, a naturally occurring chemical substance that neurons use to communicate with each other—seems to play a crucial role in OCD. The best evidence for a serotonin link to OCD is that all antidepressants that work by increasing the level of serotonin in the brain seem to help OCD, whereas those that work through other neurotransmitters usually do not. Recently, medical interest has shifted to another neurotransmitter, glutamate, which is present in higher concentrations in some parts of the brain in people with OCD and which seems to decrease to normal levels after successful treatment with medication.

However, one central question remains: are such biological features—the measurable differences in some regions of the brain, the low serotonin, and the high glutamate—present at the origins of OCD, somehow causing it, or are they the downstream effects of having suffered from this illness? These findings in the brains of patients with OCD could still turn out to be the *result* of a biological transformation the disease itself inflicts on the brain, not unlike, for instance, chronic depression, which has been shown to lead over time to a visible shrinking of the

hippocampus, a region of the brain that is important in memory storage and processing.

Another important argument in support of the biological roots of OCD is the genetic link. The percentage of identical twins in which both individuals have OCD is consistently higher than that of fraternal twins. Given that the environmental influences are the same among identical and fraternal twins but that only identical twins share the same genetic material, an argument has been made for the importance of “nature” over “nurture” in the development of OCD.

Nature or biology, however, can offer only part of the answer. Various schools of psychology have also tried to explain OCD. The oldest, most colorful, and probably most discredited psychological explanation is the model offered by Freudian psychoanalysis. In his book *Notes upon a Case of Obsessional Neurosis*, first published in 1909, Sigmund Freud describes Ernst Lanzer, or Rat Man, a young university-educated man with intrusive thoughts of seeing and touching nude girls (the obsession) and an associated fear that, if he did not control these impulses, he would somehow cause significant harm to happen to his father. Specifically, he feared that his father would be subjected to a particularly cruel form of torture: having rats burrow into his anus while he was tied up—hence the pseudonym Rat Man. Rat Man developed elaborate rituals (the compulsion) around these thoughts to help reduce his anxiety and ward off the impending evil. Freud, through an analysis of the patient’s sexual development, saw Rat Man’s symptoms as manifestations of horror and guilt over some early, prohibited sexual fantasies he had as a child that were now stored in the unconscious mind, surfacing in the form of disturbing obsessions and waiting to be processed with the help of psychoanalysis.

Psychoanalytic exploration then aims at uncovering the repressed fear at the basis of these symptoms and resolving the underlying conflicts. According to this theory, such uncovering, by making the unconscious conscious, would lead to recovery from OCD. After analyzing Rat Man for one year using this approach, Freud pronounced his patient cured. However, not much is known about the long-term success of Freud's intervention: Ernst Lanzer died in the fields of World War I.

Evolutionary psychology approaches the OCD problem through the Darwinian lens of natural selection based on overall fitness for survival. One can see how it might be helpful for our species to possess the ability to generate anxiety-provoking obsessions while in a safe environment because these can help the brain to learn and practice risk avoidance behaviors; should the organism then be faced with a real threat from the environment, this "safety training" could serve as a good template to follow. It is intriguing to note, for instance, how often the elaborate obsessions and compulsions seen in OCD can be reduced to the common themes of safety and self-preservation: washing protects against disease, hoarding food protects against famine, and frequent checking of the environment keeps us out of harm's way. In the individual with OCD, it is thought, these basically good, potentially life-saving traits are somehow disinhibited and allowed to go unchecked, so to speak.



George did not wish to approach his OCD as a novel with villains and victims. He didn't see a very convincing connection between his brother's untimely death or his wife's hoarding problem on the one hand and the onset of his OCD symptoms or the nature of

these symptoms on the other. The most he would agree to was that the overall level of stress that his brother's death and his wife's condition had caused him somehow made his OCD vulnerability, which had already been there, finally express itself.

And I basically agreed. I felt that pursuing these impossible-to-prove associations too forcefully, against George's stated preference, could paradoxically lead him to attribute meaning to symptoms that he saw as essentially meaningless and indefensible. Following a psychoanalytic approach that imbued symptoms with a rational dimension through cause-and-effect linkages ran the risk of making them meaningful, and hence perhaps worthy of holding on to.

Instead, the idea of OCD as a chemical imbalance that happens for reasons we do not fully understand is what resonated with George, in part because it removed the blame: it was no longer a personal failing on his part, nor was it his brother's or wife's fault. He had researched the serotonin hypothesis for OCD and favored a chemical solution to what he viewed as essentially a chemical problem.

"So what SSRI are you starting me on?" George asked at the beginning of our third meeting, before I had fully discussed pharmacological treatments with him.

"I'm very impressed," I said. "It looks like you've done your homework. Do you know how these medications work?"

"Something about serotonin," George answered.

"Indeed," I said. "Selective serotonin reuptake inhibitors, or SSRIs, work by increasing levels of serotonin in the brain."

"What's the likelihood of them working?" he wanted to know.

"The response rate is around 50 to 60 percent, and it seems similar across all SSRIs," I told him.

“So how do you decide which one to give, then?” he asked.

“Well, I decide in part based on any previous medication trials you may have had,” I explained. “It’s also important to consider what else you may be taking currently, because drugs can interact with each other. If you have family members with OCD, we should look at what medications they responded to, since there seems to be a genetic component to response, just like there’s a genetic component to having OCD.”

“Well, I’ve never been treated for OCD before,” George said. “I don’t take any other meds, and I have no blood relatives with OCD to help guide us. So it’s a clean slate!”

“Well, this leaves us with side-effect profiles to help us decide,” I suggested. “The most likely side effect to this class of medications in a healthy young man would probably be sexual.”

“I cannot even hug my wife, let alone think of having sex.” George answered, smiling slightly at the irony. “Sexual side effects are simply not an issue for me right now.”

“Well, let’s start Zoloft, then,” I said. “It’s relatively clean and well tolerated. As with all SSRIs, though, when taking them for OCD, you have to wait up to ten weeks for a response. The starting dose is usually 50 mg daily, and our target will be 100 to 200 mgs, if we’re not limited by side effects.”



Although first developed as antidepressants, selective serotonin reuptake inhibitors (SSRIs) have been shown to be effective in several anxiety disorders, including OCD. In double-blind placebo-controlled research studies, neither the investigators conducting the study nor the subjects participating in it know who is taking an active drug and who is taking an identical-looking sugar

pill, or placebo. These studies are considered the gold standard for establishing a drug's efficacy, and all six SSRIs currently available in the United States have passed the double-blind test, with at least one large study yielding positive results. Hence, fluvoxamine (Luvox), fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), citalopram (Celexa), and escitalopram (Lexapro) can all be considered reasonable first-line pharmacological treatments for OCD, although not all have been approved by the U.S. Food and Drug Administration (FDA) for that purpose. (It is not uncommon for medications to be effective in, and prescribed for, conditions for which they do not carry FDA approval.)

Looking at these studies as a group, we can draw several conclusions useful in guiding treatment. First, about 50 to 60 percent of patients with OCD respond to treatment with an SSRI. Also, higher doses of the SSRI are usually required to treat OCD than what is generally needed for depression, and the length of treatment before a response is seen is generally longer (about ten weeks for OCD compared to about four weeks for depression). Moreover, despite the fact that all SSRIs work by raising serotonin levels in the brain, patients with OCD who do not respond to one SSRI still have a good chance of responding to another one. Finally, despite the high doses often required, these medications appear to be generally well tolerated. A discussion of second-line pharmacological treatments for OCD and of the many ways in which medications are combined is beyond the scope of this book.

Drugs alone, however, are often not sufficient to treat OCD and may lead to high relapse rates after they are discontinued, whereas therapy, it is argued, can teach the patient tools that last a lifetime. For many patients, combining medications with a

form of therapy known as *cognitive behavioral therapy*, or CBT, offers the most relief. Unlike psychoanalysis, CBT has proved effective in well-designed studies. In CBT, the patient is asked to develop a hierarchy of feared OCD scenarios and is then exposed to gradually escalating situations over several therapy sessions, starting with the least feared and progressing through the list. For example, Craig, a thirty-something lawyer I treated for OCD, had a severe contamination obsession that prevented him from using the bathroom at the law firm where he worked. I started Craig's treatment by asking him to simply walk past the bathroom once daily for a week. After one week, I asked Craig to open the bathroom door once a day without going inside. The "homework" gradually became more demanding, requiring Craig to walk into the bathroom daily and use the sink, then the urinal, until finally I was able to ask him to confront the worst fear he listed on his hierarchy, namely, using the toilet. We addressed Craig's accompanying ritual of excessive hand-washing similarly, by gradually reducing the amount of time he was allowed to keep the water running.

And as I walked Craig through the hierarchy of feared situations, I encouraged him to "ride the anxiety wave," teaching him relaxation techniques like deep breathing and giving him copious reassurances that the more he faced the obsession and the more he avoided the ritual, the easier it would become for him to do so.

However, OCD symptoms are often so severe that the patient is unable to engage in meaningful therapy. Cognitive behavioral therapy is a collaborative approach that assumes a motivated patient willing and able to come into the therapist's office for what is usually an hourly session every week for several months. The therapist assigns homework that the patient is expected to

complete between sessions and holds the patient accountable for failure to do so. Such work is impossible with patients who are difficult to engage or who cannot leave their house, drive a car, or come into a clinic building because of the severity of their OCD symptoms. So, when a patient's personality or the severity of symptoms precludes adequate cognitive behavioral therapy, medication should be started alone, with the option of incorporating therapy into the treatment once the patient improves and is better able to engage in therapy and tolerate its requirements.



In addition to being his prescribing doctor, I wanted to serve as George's therapist, and in many ways, George would have been an ideal candidate for therapy. A responsible and inquisitive young man, he seemed to have the youth and mental flexibility needed for change and the creativity and faith to see how the talking process can alter brain chemistry enough to effect this change. Using the cognitive behavioral model, I imagined myself assigning him homework and his reporting back to me on his weekly progress. I imagined focusing first on the basic tasks needed to meet some vital needs, such as food and hygiene. For instance, I would start by increasing his comfort level with eating utensils, while working on his fear of the showerhead. We could then move toward getting him back to work, perhaps part-time initially, maybe in an expanded cubicle. I would also try to help him gradually feel comfortable being intimate with his wife again—maybe have him move back into the house at first but sleep in a different room, then in the same room but on the floor, then in the same bed, then have him hold her hand, then hug her, then . . . But so much for my plans for therapy—it was impossible to get George to come in for

the regular sessions needed to make it happen. The length of time it took him to work through his anxiety just to make it to his appointments caused him to miss several sessions and created an almost impossible therapy relationship.

George *was*, however, very committed to taking his medication. So instead of face-to-face weekly clinic meetings, I made the decision to treat him with the medication alone at first, and I monitored his progress and any side effects through phone contact every other week. I still fantasized, though, about the step-by-step therapy course I would take him through and thought that the strong doctor-patient alliance, of the kind that could be achieved only through intensive therapy, was indispensable for a successful outcome in his case. In my mind, it was a matter of when, not if, I would bring therapy to the aid of Zoloft.

But by our second phone contact after starting the medication (his fifth week on it), George's voice already sounded somehow significantly more resonant and self-assured. Could it be that my therapy intervention might not be needed after all?

"You sound clearer today, George," I commented. "Are you feeling better?"

"I am," George said. Then, sounding almost euphoric, he added, "But there's also a technical reason for why I sound better."

"A technical reason?" I asked. "What is it?"

"Well, I'm calling from home, which helps," he answered, "and I'm actually able to use the handset today! When I spoke with you before, I had to be on the speaker phone. I couldn't tolerate the handset so close to my nose."

"This is great, George," I exclaimed. "Did you have to push yourself to use the handset for our phone call today? How much of a struggle was it?"

“It really wasn’t a struggle at all,” George answered. “I just didn’t think about it. It somehow didn’t occur to me today that the handset would hurt my nose. I only realized after dialing your number that, oh my God, I’m actually holding the phone! My only explanation is that the Zoloft must be doing its thing already . . .

“I think you’re right,” I agreed. “I think we’re seeing an early response. That’s wonderful news that . . .”

“And I have more wonderful news for you,” George interrupted. “I also had a real shower this morning for the first time in a long while. I feel fresh for a change.”

“I’m sure that helps, too,” I said. “How about another basic function, eating? Are you still afraid of utensils and solid foods and can only drink fluids?”

“I certainly can’t handle pizza yet,” George answered. “The wedge thing still bothers me, so do knives and forks, but the good news on that front is that I can tolerate spoons now! For some reason, I’m more comfortable with round forms approaching my nose than pointy edges. That’s how I could eat a hamburger yesterday—a fat juicy one that tasted like the best burger I ever had!”

“It’s so nice to see you come out of this, George,” I said. “We’re only at week five, so we can still expect more improvement over the next couple of weeks. As I told you, many patients don’t get better until week ten or so.”

“Let’s up the dose anyway, Doc!” George suggested.

“Well, you’re tolerating 50mg pretty well, so let’s go up to 100mg and stay there for a while,” I concurred. “Call me at the same time in two weeks, and we’ll reassess.”

But before I could let George go, I had to inquire about his wife’s hoarding. I had decided that her behavior was contributing

to my patient's symptoms by increasing the ambient stress in the household, so I felt justified inquiring into it.

"Before you go," I said, "can I ask you how your wife is doing with her hoarding these days? You said you moved back in, so I want to be optimistic and think that the house feels more hospitable to you. I realize it's not my place to treat her, but . . ."

"Funny you should ask!" George broke in. "You know, her mother who's a neat freak, her father who's a perfectionist in his own right, and I who worry about hurting my nose, all have for years been telling her to clean up the house but to no avail. Until, that is, your Dawn caught her in the act of stocking up! Well, I'm glad to report that your assistant's intervention is working where nothing else ever has! Maybe out of embarrassment over what happened, my wife has for the first time decided to confront her problem. She has finally agreed to hire a professional declutterer that her mom recommended, a very methodical woman with a stern old nun quality to her who will not take no for an answer when my wife refuses to let her throw something away—exactly what my wife needs! Well, 'Mother Superior,' as we started calling her, has already begun her journey into the heart of darkness that is our kitchen. The output so far, in case you're wondering? Fifteen boxes of cooking magazines, yellowed with age, not with extra virgin olive oil stains!"



Hoarding is defined as the acquisition and difficulty getting rid of worthless items. About 20 percent of patients with OCD have as their most prominent symptoms compulsive hoarding and obsessive fears of throwing out items that might be needed in the future. Items most commonly saved include magazines, newspapers, old

clothing, mail (including junk mail), and lists of all kinds. Although such collecting can be problematic in all age groups, the elderly are especially vulnerable due to the real threat it can pose to their safety by causing falls, fires, and the inability to prepare food or adhere to medication regimens because of difficulty navigating their kitchens or finding their pills.

Hoarding appears to differ on several important fronts from more “classic” symptoms of OCD, such as contamination fears or excessive checking. This has caused experts to wonder whether hoarding is a distinct disorder altogether rather than simply a form of OCD. For instance, compared to other presentations of OCD, hoarding-type OCD is generally much less responsive to treatment, especially pharmacological interventions, and only mildly responsive to therapy. Furthermore, imaging studies of the brain have shown different rates of metabolic activity in some brain regions among hoarders compared to people who have OCD but do not hoard.



Semana Santa, or Holy Week, has always been a very special time of year for Dawn. It is the culmination of a process that begins on Ash Wednesday, when Dawn arrives earlier than usual for work after morning Mass, bearing an ashen cross imprinted on her forehead. This is the official beginning of the Lent season for her, a forty-day period leading up to Easter that she observes by completely avoiding meat and adhering, well, religiously, to a strict fasting regimen that starts at sunrise and ends at sunset every day.

Watching Dawn follow this Catholic ritual every year helps punctuate the calendar for the rest of the clinic staff too. Several national and international medical meetings happen in late

spring because of the generally good travel weather. Dawn's fast, which usually falls sometime in April, is a good wake-up call, reminding us that conference deadlines are fast approaching and that by the time Dawn breaks her fast at the end of Lent, we should have ended our procrastination and finished writing up the research to be presented at these meetings. Otherwise it will be too late. So, indirectly, Dawn's annual fast is generally beneficial to the non-Catholics in the clinic as well, inspiring increased productivity on everyone's part. Perhaps because of this fringe benefit, we are more tolerant than we might otherwise be of the slight increase in irritability, which slowly builds up in Dawn through the day every day during Lent as her hunger pangs gradually worsen.

But Dawn's ascetic self-denial for forty long days only heightens the drama of what comes next: the ritual-heavy *Semana Santa*, or Holy Week, building up to Easter Sunday. Palm Sunday is the official start of *Semana Santa*, commemorating for Christians Jesus's entry into Jerusalem; in preparation, Dawn breaks off small branches from the dwarf palm tree in our parking lot and takes them home for decoration. Spy Wednesday comes a few days later and recalls Judas's spying on Jesus; Dawn commemorates that by leaving work early to go to Mass. The following day is Maundy Thursday, when the story of Jesus's Last Supper is retold; Dawn also marks it by leaving work early to go to Mass. Then comes Good Friday, recalling Christ's Crucifixion and burial; out of respect, Dawn wears all black that day and avoids makeup. Holy Saturday follows next, and, sometime between sundown on Holy Saturday and the morning of Easter Sunday, when Resurrection is celebrated, a Mass takes place that constitutes for Dawn the absolute liturgical highlight of her

year—until the following year, that is, when the entire cycle is played out again.



Rituals are woven into the fabric of our daily lives. It seems as though rituals, performed automatically and according to inherited, rarely questioned recipes, are the glue that holds a group together, setting it aside from other groups—with different rituals—but also connecting it with past and future generations. In our remarkable willingness to partake in, and pass on, rituals like the Passover Seder, graduation ceremonies, burials, coronations, or the Thanksgiving menu, we express a built-in need for fixed behaviors that repeat themselves, unchanged, over time. This constancy comforts us and punctuates our lives, bringing us order, or *seder* in Hebrew. It is also a big part of what defines culture.

How, then, do the ritualistic behaviors we see in OCD fit into this generally positive function of rituals in our lives? Without getting into a moot discussion of how much is too much, we can safely start by saying that OCD rituals are excessive. But deeper than that, OCD rituals either become an end unto themselves or are performed in response to mounting anxiety. In other words, the elaborate, time-consuming rituals we see in OCD are bereft of the symbolism and meaning that something like a bar mitzvah celebration can command. Furthermore, OCD rituals tend to be self-generated. Unlike, say, Judaism's and Islam's proscription against eating pork, a tradition which practicing parents inculcate in their children and which can then become a lifelong connection with ancestors and faith, a patient with OCD who suddenly develops an irrational fear of eating chicken is acting largely independently and not sharing in a communal practice. In this case,

ritual becomes an isolating oddity rather than a shared behavior that, although perhaps a bit peculiar to some observers, still fosters community and encourages engagement.



Exactly two weeks after our last phone contact, at the time of the scheduled call, instead of my phone ringing I heard an assertive knock on my door. It was George, only much cleaner than at our last face-to-face meeting some two months before. His wife stood next to him, her svelte frame curving slightly in George's direction under pressure from his arm, which he had wrapped tightly around her waist. The sight of the intimate-looking couple clearly indicated to me that the three-, two-, or even one-foot rule was no longer in effect—and that George was probably not having sexual side effects!

"What a nice surprise!" I said, addressing George. "You look great."

"Doesn't he now?" his wife beamed. "I have my husband back. He even drove us here!"

"*And* we have a gift for you," George said, handing me a wedge-shaped present wrapped in aluminum foil and smelling of pepperoni.

"You brought me pizza?" I asked, surprised and moved by this gesture.

"Yes," George answered. "I bet no patient has ever given you pizza before!"

"No, no patient ever has," I concurred. "This is a first indeed. Thank you."

"Well, pizza has been a recurring theme in our conversations," George explained, "and, in a way, it's the best measure of both

how silly and how disabling my OCD was. All this makes it a fitting final thank-you gift.”

“Well, I’m very touched, George,” I said. “Thank you again.”

“Wait!” his wife interjected, “It gets even better . . .

“How much better can it get?” I asked, wondering what other pleasant surprises the couple had in store for me.

“It’s homemade!” George exclaimed, elated at the thought of a home-cooked meal.

“You’re able to use your stove again?” I almost gasped, looking at George’s wife.

“I can indeed!” she said proudly, “and we have our declutterer, or ‘Mother Superior,’ to thank for it! I just have to make sure I maintain now. ‘For each item that makes it into the sanctum of your home, an equal or larger item has to exit,’ she ceremoniously warned me at our last meeting.”

“In my experience, that is probably the best advice for hoarders and more likely to help than any medication or even therapy intervention,” I agreed. “Your approach of having someone do the throwing for you while you deal with the anxiety this generates, and while you work on maintaining the result, is probably the way to go.” Then, turning toward George, I said, “What *you* have to maintain, and probably for a while, is your medication.”

“Oh, don’t worry, Doc,” George said. “I don’t plan to stop it anytime soon.” Then he added, half-jokingly, “But my wife has a burning question for you. It’s been keeping her up at night!”

“What’s your question?” I asked.

“Is it true, Doctor, that animals, too, can get OCD?” she asked, leaning in my direction and looking intently into my eyes as though she had indeed been burning to ask the question.

“And where did you hear of such a thing?” I queried.

“Well, a magazine I discovered behind the stove while cleaning the kitchen had an article saying that dogs, too, can get OCD,” she said. “Apparently, they start cleaning and licking themselves, and they just can’t stop! Some even get infections and die from it. And if all this was not shocking enough, the article talks about medications in the Zoloft family that can actually cure them! I had to hide the magazine and save it from ‘Mother Superior,’ of course. In case we ever have a dog with OCD, at least we’ll know how to treat him!”

“And do you have a dog now?” I asked, trying to empathize with her worry but also quite amused by it.

“We have two,” she answered.

“And do they have this problem?” I wondered.

“No, only normal licking,” she said.

“Well,” I said, trying hard not to laugh, “animal models for OCD have been described. What you read about is something called ‘canine acral lick dermatitis.’ These are dogs who compulsively lick their paws until they bleed, often getting serious infections. And as you said, studies of these dogs have suggested that SSRIs can actually stop the behavior.”

“I hope our dogs never get OCD,” she said, looking at George and appearing more anxious at the remote possibility of this problem than satisfied with my explanation.

“Don’t worry,” I tried to reassure her. “This is an extremely rare condition, so you should feel completely free to recycle that article!”

“But what if they do?” she said, her anxiety escalating even further at the idea of recycling something. “What if one of my dogs catches OCD one day, and I have to reread the article?”

“I can see Mother Superior hasn’t completely taken care of the hoarder in you,” George interrupted, chuckling.

I chuckled, too, and after a long pause, so did George’s wife.

Later, watching George walk away from my office, his arm wrapped around his wife’s waist, all I could think was how satisfying my cold pizza was going to be. With anticipation, I reached for the carefully wrapped wedge, slowly undoing the aluminum foil as I comfortably plopped myself in the oversized patient chair, turning it around so I could face the window. I propped my feet on the windowsill and prepared to take my first bite. But just as I was about to do so, an interesting scene unfolding in the parking lot outside my window caught my eye. I saw Dawn, all in black in observance of Good Friday, trying to catch up with George’s wife, carrying what looked like a tall stack of magazines she had saved for her. George’s wife gave her a big hug but declined the apparent gift, as suggested by Dawn energetically tossing the entire stack into the dumpster. The three then conversed briefly before George opened his trunk, and all joined forces to pull out a familiar-looking old table, each holding one of three remaining legs.

Pizza never tasted so good.