



Fear and Courage During Psychological Treatment of OCD

By Laurie Krauth, MA
Ann Arbor, MI

People with OCD display extraordinary courage in fighting a disorder that, by its very nature, torments them with equally extraordinary fear, according to a leading expert on OCD.



Dr. Jack Rachman

"People whose problem is intense fear behave courageously on a day-to-day basis," Jack Rachman, Ph.D., professor emeritus

at the University of British Columbia, said in the Keynote Address to the 12th Annual OCF Conference in San Diego on July 30, 2005.

"Having intense fears doesn't preclude courage," said Dr. Rachman, the author and editor of numerous books and articles on OCD and other anxiety disorders. In fact, courage can be learned and cultivated. "Ordinary, average citi-

zens are capable of courageous behavior," he said.

OCD clients can develop their capacity for courage, encouraged by the clinicians who help them. Courage is central to the principal OCD treatment of exposure and response prevention (ERP), which is a part of cognitive-behavioral therapy. With ERP, clients choose to actively expose themselves to their obsessive thoughts and resist performing the physical and mental rituals they normally use to allay their anxiety. It takes great courage for someone to choose to feel and even heighten anxiety and then not give in to the intense desire to reduce it through ritualizing.

Ironically, it took the courage of British psychologist Victor Meyer almost 40 years ago to bring this courage-based therapy to OCD treatment.

"What he did was very brave," said Dr. Rachman. Dr. Meyer applied to humans what studies had shown applied to frightened animals: if they were exposed to what scared them for a pro-

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Message From the President

Dear Friends,

In 1986 the Obsessive Compulsive Foundation was formed. It was then and is now the goal of the OCF to find "Effective Treatment for Everyone." With this in mind, the Foundation responds to all your inquiries that come into our office in New Haven. Info Packets are mailed out to those who request further information. Patricia Perkins, one of the original founding members and our current Executive Director, also a sufferer of OCD, knows how important it is to find the right treatment. She and the staff at the Foundation listen to your calls and try to provide information and support in finding help with your OCD.



The OCF Scientific Advisory Board, chaired by Dr. Michael Jenike, keeps the Board of Directors informed as to the new approaches that are being explored by medical investigators worldwide. Through donations from our members and friends, the Foundation has been able to respond to research proposals that have been submitted to the Foundation for funding. In the past nineteen years since the Foundation's inception, there has been a great deal of progress in the area of providing treatment for everyone. We, as a Foundation, do not restrict our support to one particular approach. It is our job to inform you of what is being done by these researchers. Our articles in the newsletter, our annual OCF

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"Call For Proposals" for the 2006 OCF Research Awards

The OC Foundation is issuing its "Call for Proposals" for 2006, inviting investigators to submit grant applications for these awards. Because the Foundation is committed to finding and promoting "Effective Treatment for Everyone with OCD," it is interested in funding research into studies on the brain, its chemistry, structure and functioning; neurobiology; the genetics of OCD; its epidemiology; its economic effects on the sufferers, their families and the national economy; the pathophysiology of OCD; and all aspects of OCD and the OC spectrum disorders that could lead to prevention and treatment advances.

The deadline for submitting a proposal for the 2006 OCF Research Awards is January

13, 2006. For application guidelines or more information about the awards, please contact Jeannette Cole, OCF Deputy Director, at cole@ocfoundation.org or call 203-401-2069.

This year, the Foundation's Board of Directors granted six* OCF Research Awards. The topics included genetics research, augmentation strategies, sudden gains with CBT and treatment enhancement interventions. The total of the 2005 grants is \$257,351.12. From 1994 through 2005, the OCF has awarded \$1,400,440.00 to investigators researching OCD and the OC spectrum disorders.

*The OCF Board of Directors recently voted to fund a sixth award.

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Bulletin Board

BODY DYSMORPHIC DISORDER STUDY

People with body dysmorphic disorder (BDD) worry about their appearance, thinking there's something wrong with how they look. BDD usually begins during childhood or adolescence but very little is known about what treatments help this age group. Research is greatly needed to answer this important question. We are studying the effectiveness of the medication fluoxetine for children and adolescents ages 10-16 with BDD who qualify for our study. This study is being done by BDD experts at the Mount Sinai Medical Center in New York, New York (Dr. Eric Hollander); Butler Hospital/Brown Medical School in Providence, Rhode Island (Dr. Katharine Phillips); and The University of Cincinnati School of Medicine in Cincinnati, Ohio (Drs. Brian McConville and Susan McElroy). People who qualify will receive free study treatment and are paid for their participation. Please contact us if you are interested in participating:

Mary Walters

BDD and Body Image Program

Butler Hospital

Providence, RI Tel: (401) 455-6466

E-mail: mwalters@butler.org

Web site: www.bodyimageprogram.com

Suah Kim

Mount Sinai School of Medicine

New York, NY Tel: (212) 369-5123

E-mail: suah.kim@mssm.edu

Web site: www.mssm.edu/psychiatry/ciadv

Judy Depew

The University of Cincinnati School of Medicine

Cincinnati, OH Tel: (513) 558-3991

E-mail: judy.depew@psychiatry.uc.edu

HAVE YOU BEEN DIAGNOSED WITH OBSESSIVE-COMPULSIVE DISORDER (OCD)?

Are you currently taking medicine for OCD but have found little or no relief from your symptoms?

If your answer is "yes," you may qualify for a no-cost research study designed to evaluate the effectiveness of adding a marketed medication for investigational use to a serotonin reuptake inhibitor (SRI) in the treatment of OCD. Eligible participants must be over 18 years of age and currently taking an SRI medication for OCD. The research study is being conducted by Dr. Eric Hollander at Mt. Sinai's Compulsive, Impulsive and Anxiety Disorders Program. For more information, please call 212-369-5123. (GCO#04-0379PS, IRB approved through 8/30/06).

OCD SIBLING/TWIN STUDY

Researchers in a study at the National Institute of Mental Health are looking for pairs up to age 65 where one sibling has been diagnosed with obsessive-compulsive disorder (OCD) prior to age 18 and looking for pairs up to age 65 where either one or both twins have been diagnosed with obsessive-compulsive disorder (OCD) prior to age 18. This is a brain-imaging study using Magnetic Resonance Imaging (no radiation) in Bethesda, MD.

Child Psychiatry Branch
National Institute of Mental Health
National Institutes of Health
Department of Health and Human Services

Travel expenses and accommodations paid in full.

Please Contact:

Wendy Sharp, MSW

(301) 496-0851 or (888) 254-3823

sharpw@mail.nih.gov

DOES YOUR CHILD OR TEENAGER TAKE MEDICATION FOR OCD?

Many children and adolescents who take medication for OCD still suffer from OCD symptoms that can interfere with school, work, and relationships with family and friends.

Dr. John March at Duke University, Dr. Martin Franklin at the University of Pennsylvania, and Dr. Henrietta Leonard at Brown University are conducting a multi-site study evaluating the effectiveness of adding two different types of cognitive-behavioral therapy (CBT) to ongoing medication management for the treatment of pediatric OCD that does not respond completely to medication treatment.

Participants in this study will receive medication management free of charge. In addition, they may be assigned to receive CBT at no cost from a psychiatrist or a psychologist.

Children ages 7-17 with a diagnosis of OCD, who are taking fluoxetine (Prozac), sertraline (Zoloft), or fluvoxamine (Luvox), and who still have residual OCD symptoms may be eligible. Children taking citalopram (Celexa) or escitalopram (Lexapro) may also be eligible.

Participants must live within commuting distance of Raleigh/Durham, NC; Philadelphia, PA; or Providence, RI.

Contact information:

Duke University, Durham, NC
Rebecca Dingfelder, (919) 416-2447
dingf002@mc.duke.edu

University of Pennsylvania,
Philadelphia, PA
Radhika Pasupuleti, (215) 746-3331

radhikap@mail.med.upenn.edu

Brown University, Providence, RI

Janet Ng, (401) 444-2178

jng@lifespan.org

DO YOU SUFFER FROM TOURETTE SYNDROME OR CHRONIC TIC DISORDER?

Do you have motor and vocal tics (movements or noises/voices that are hard to control)? Do the tics occur several times a day? Have the tics occurred over a period of more than one year? Are you diagnosed with Tourette Syndrome or Chronic Tic Disorder? Do you have problems with your work or social life because of this?

Dr. Sabine Wilhelm of the Massachusetts General Hospital OCD/Tourette Syndrome Clinic and Research Unit is seeking partic-

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OCD NEWSLETTER

The OCD Newsletter is published six times a year.

Obsessive Compulsive Foundation, Inc.

Phone: (203) 401-2070

Fax: (203) 401-2076

E-mail: info@ocfoundation.org

Web site: www.ocfoundation.org

Joy Kant, President,

Board of Directors

Patricia B. Perkins, J.D.,

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Scientific Advisory Board

The Obsessive Compulsive Foundation (OCF) is a not-for-profit organization. Its mission is to increase research into, treatment for and understanding of obsessive-compulsive disorder (OCD). In addition to its bi-monthly newsletter, OCF resources and activities include: an annual membership conference, Web site, training programs for mental health professionals, annual research awards, affiliates and support groups throughout the United States and Canada, the distribution of Info Packets, referrals to treatment providers, and the distribution of books and pamphlets through the OCF bookstore.

DISCLAIMER: OCF does not endorse any of the medications, treatments, or products reported in this newsletter. This information is intended only to keep you informed. We strongly advise that you check any medications, products or treatments mentioned with your treatment provider.

For Parents: How To Talk So Schools Will Listen

By Jule B. Monnens, RN, MSN
Centennial, CO

One of the hardest jobs for parents of children with OCD and other special needs is knowing how to "work the system."

In your advocacy journey you will need two things: accurate information and support. You need accurate information and practical advice, and a toolbox of skills and resources you can use to be an educated consumer and effective advocate for your child.

Children with a diagnosed neurobiological brain disorder or disability such as OCD are guaranteed a Free and Appropriate Public Education (FAPE). The guarantee is the result of three federal laws: Public Law 94-142, the Education of All Handicapped Children Act; Public Law 105-17, the Individuals with Disabilities Education Act (IDEA), and Section 504 of the Rehabilitation Act of 1973.

Children with these and other disabilities must receive access, when needed, to special education and/or related services. The special education program or services must be designed to meet your child's unique educational needs through and Individualized Education Program (IEP) or a Section 504 plan tailored to your child's specific needs. The IEP is an education program, while the 504 plan is an accommodation and accessibility program. Each of these laws may require a multi-disciplinary team evaluation of your child to determine whether he or she qualifies for the special services.

As the parent of a child with OCD, you have two goals. Your first goal is to ensure that the school provides your child with a free and appropriate public education. Your second goal is to build and maintain a healthy working relationship with the school. If you have a business-like relationship with school staff, it will be easier to accomplish your first objective. This doesn't, however, mean that you will never have conflict.

Managing a child's special education pro-

gram is difficult and confusing for most parents. The job is harder if you don't have a master plan. If you don't know where you are and where you need to go, you won't know how to get there. Like an IEP, your master plan should include long-term goals and short-term objectives. The 5W's + H + E techniques are among the most simple and effective strategies. When you use these techniques, you ask questions. When you ask questions, you get answers. When you get answers, your fear of the unknown will decline and so will your school meeting anxiety.

When you use the 5 W's + H + E techniques, you frame sentences so they begin with one of these seven words: What? Why? When? Who? Where? How? Explain. How do you get answers to questions? You get answers when you meet with school staff. When you use 5 W's + H + E techniques several good things happen. By listening carefully, you learn how the school views your child's problems and what the school plans to do to help your child. Having this information eliminates surprises, helps you anticipate problems, and reduces fear of the unknown. Some of the questions you want answers to are:

- How does the school view my child's problems?
- What does the school think my child needs?
- What does the school think they should do about my child's problems?
- Does the school have a plan to educate my child? What are the components of this plan?
- How will I know if the school's plan is working?
- What does the school propose to do if their plan doesn't work?

Remember, ask questions, listen carefully, and don't argue. You'll be surprised at the useful information you'll discover.

When you learn that a meeting is scheduled, begin to prepare. Take out several

sheets of paper and write across the top of the first sheet: 5 W's + H + E. On the top left side of the paper write a large letter W. Drop down several lines and write another large W. Do this until you have five W's in a vertical row. Write the letter H under the W's, and the letter E under the H. Who? What? Where? When? Why? How? Explain? Now brainstorm. Write down all thoughts, questions and concerns that come into your brain. This process will help you fine-tune your questions and concerns.

You can't develop a plan of action until you know what's going on. Ask lots of questions. Take notes. Listen carefully. Don't interrupt. Ask more questions. When your questions are answered, you'll have evidence that will help you out. You'll be in position to generate better solutions to the problem.

The 5 W's + H + E techniques have another benefit. When you ask questions but don't argue, you plant the seeds of doubt. As you continue to ask questions, the school staff may begin to question its decision. To resolve conflict, remember to focus on your interests, not your position. You have two interests: to resolve the school issue and to protect your relationship with the school. The same process can also be used during phone calls. Tape a sheet of paper with 5 W's + H + E next to your phone. The next time you get an unexpected call from the school, use this paper to remind yourself to ask questions.

**PLEASE
DESIGNATE
THE OCF
AS YOUR
WORKPLACE
CHARITY OF
CHOICE**

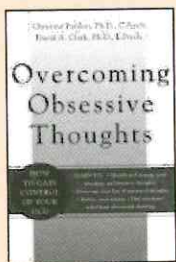
Book Review

Overcoming Obsessive Thoughts: How to Gain Control of Your OCD

By Christine Purdon, Ph.D., C. Psych.,
and David A. Clark, Ph.D., L.Psych.

Reviewed by Bradley Riemann, Ph.D.,
Clinical Director, OCD Center, Rogers
Memorial Hospital, Oconomowoc, WI

Overcoming Obsessive Thoughts: How to Gain Control of Your OCD is a self-help book written primarily for individuals whose OCD has violent, disgusting, or



blasphemous obsessive themes; but its content could easily apply to any OCD sufferer. The authors of the book are Dr. Christine Purdon and Dr. David A. Clark. Dr. Purdon is an Associate Professor in the Department of

Psychology at the University of Waterloo (Canada) and a highly recognized researcher in the field of OCD. She also maintains a private practice. Dr. Clark is a Professor in the Department of Psychology at the University of New Brunswick (Canada) and a highly acclaimed researcher. He has published widely in the field and authored or co-authored three previous books.

This extremely well-written book guides the reader through the steps necessary to identify and manage unwanted, intrusive and repugnant thoughts. Following a brief overview of OCD in the Introduction, Chapter One outlines the cognitive-behavioral treatment approach used in this book. Chapter Two helps the reader to determine whether s/he has OCD or not by providing excellent descriptions and examples of obsessions and compulsions. It also introduces the reader to "repugnant" obsessions, which include violent, sexual, or religious themes, and categories of each. The authors make this sometimes confusing material very easy to understand and follow. "Focus Exercises" are used throughout the book to help the reader understand the material that is presented. An exercise in Chapter Two distinguishing scrupulosity from strong religious devotion will prove especially helpful for those exhibiting difficulty in this area.

Chapter Three is very strong; it is an easy-to-follow explanation of how obsessions are generated. Among others, the con-

cepts of "inflated responsibility," "overestimation of threat," "thought-action fusion," "mental control," and "intolerance for uncertainty" are introduced; and the mechanisms by which these concepts influence obsessional thinking are explained. Chapter Four allows readers to identify their symptom profile, while Chapter Five explains why OCD persists despite efforts to control it. Chapter Six assesses possible obstacles to making the changes necessary to manage your OCD (e.g., overvalued ideation, fears of others' reactions).

Chapter Seven discusses the "Paradox of Mental Control." In this chapter, the reader sees how the more s/he attempts to control her/his obsessive thinking by trying to push these thoughts out of her/his mind, the stronger the obsessional thoughts become. Chapters Eight, Nine, and Ten provide detailed, research-based, practical strategies for managing obsessive thoughts and compulsions. The book concludes with Chapter Eleven, which discusses relapse prevention.

Overall, this book will prove to be very useful for any OCD sufferer, but it is extremely helpful for people with the rarely discussed subtypes involving violent, sexual, or religious obsessions. I believe this book provides the most detailed descriptions and best treatment suggestions for these often misunderstood areas of OCD.

The authors do a great job in making difficult material easy to understand and follow. They cite the latest research, much of which they have done themselves, in support of the ideas and suggestions they propose. The "Focus Exercises" they use throughout the book are clear and extremely useful in helping them explain these concepts and in helping readers gather the information they will need to undertake the treatment strategies suggested in the book. I also believe this book will prove useful for clinicians and students as well. One of the reasons repugnant obsessions are rarely discussed in the literature is that many of us treatment providers don't really understand them either. This book provides that understanding and ways to apply this knowledge to our clients.

Affiliate News

OCF Chicago Launches Clergy Outreach Program

Clergy often encounter people with OCD in the course of their ministries. During marriage and family counseling, ministering to the sick, and interacting with congregations, the clergy hear about hoarding, contamination obsessions, reassurance seeking, scrupulosity, and other OCD symptoms. People with OCD often confide in their religious advisors before seeking help from mental health professionals. With accurate information about OCD, religious leaders can recognize these symptoms as signs of a treatable mental illness, and guide people to appropriate and effective treatment.

The Obsessive Compulsive Foundation of Chicago has initiated a Clergy Outreach Program to inform clergy how to recognize obsessive-compulsive behavior. Through OCF Chicago, religious leaders and their congregations can obtain the information and support that people with OCD need to learn to manage the disorder.

The program was launched in April, 2005, when the Archdiocese of Chicago published a newsletter article submitted by OCF Chicago in "Chicago Priests: Ongoing Formation." Articles and brochures about OCD have been submitted to religious organizations of various faiths, along with information about the recently redesigned OCF Chicago web site. The program will also reach seminarians, and provide bulletin inserts for distribution during Mental Health Month.

Of particular interest to clergy is scrupulosity, a form of obsessive-compulsive disorder involving religious beliefs. According to Fred Penzel, Ph.D., "...religion and matters of religious practice...[are] a prime target for obsessive thoughts." Scrupulosity can take many forms, including fear of breaking a religious law, fear of hell or punishment, obsessions about incorrectly reciting prayers, and intrusive blasphemous thoughts.

"There are many who, no doubt, suffer in silence, feeling too embarrassed or worried that they will be thought crazy or branded as religious outcasts," explains Dr. Penzel. "When people do seek help, they often turn first to their religious leaders. If they are fortunate, this person will have at least some understanding of problems of this type."

Scrupulosity responds to the same medical and therapeutic interventions as other forms of OCD. However, in cases of religious scrupulosity, the individual's religious advisor and mental health professional work together to ensure sensitivity and an understanding of the religious beliefs at issue. When members of the clergy recognize the symptoms and

(continued on page 14)

OCA - A Place For Healing

By Roy C

Do you want support while you are working to recover from OCD? Would you like to work on your recovery with people who have the same problems and understand what you are going through? Do you want a place to heal?

Obsessive Compulsive Anonymous (OCA) can be that place, a forum for healing and recovery. 12 Step OCA meetings are **structured** with a format and at the same time they allow members to speak from the heart. We rotate between four meeting types. **Story** meetings - reading and discussion of one of the stories in the OCA manual, *Obsessive Compulsive Anonymous - Recovering from Obsessive Compulsive Disorder*. **Step** meetings - reading and discussion of one of the 12 steps. **Topic** meetings - focus on an issue common with OCD recovery and **Qualifications** - a group member tells his/her personal story and discussion follows. Each meeting takes on its own flavor as a result and the focus is moved away from the illness of OCD and onto a path of recovery.

Now what path are we talking about? 12 Step programs have many suggestions and tools that we use to help one another. First and foremost are the 12 Steps themselves - adapted for OCD. The 12 Steps are not a cookbook for OCD recovery but instead are a path for living that involves **accepting** the problem of OCD (Step 1), looking for help outside oneself in a group and from a Higher Power (Steps, 2,3 & 11), assessing the damage done as a result of our illness and personal difficulties (Steps 4,5,6,7 & 10), repairing and forgiving (Steps 8 & 9) and helping the next person along (Step 12) which leads you back to the beginning!

OCA meetings also have many **Tools** which keep things simple for us in difficult moments. **Slogans** are just that - compact bits of information that keep things in perspective in an otherwise too busy head. The following are some important slogans:

- Live and Let Live
- First Things First
- Don't Analyze - Utilize
- Keep It in the Now
- FEAR (Face Everything and Recover)

Other tools include the **Telephone** where we can call each other for support and program advice. Often we speak with our **Sponsors** - people in the OCA who have

achieved some recovery who can help us. A sponsor shares his/her experience in OCA and the path to 12 Step living. A sponsor doesn't try to "figure out" OCD or offer endless reassurances to obsessions - instead the focus is shifted away from the illness and onto a path of personal and spiritual growth.

Prayer and Meditation are important in the OCA program. Simply setting aside a few minutes a day to clear one's mind in meditation can help enormously in a mind on overdrive. For many of us praying is not about rigid dogma or rules - it is about connecting with a strength outside ourselves and looking for acceptance in what each day brings.

Lastly, **Service** is an important tool in OCA. OCA meetings have rotating leadership which allows for different people running a single meeting. We have literature people and treasurers who pay our rent from our voluntary group donations. By rotating responsibility and giving service, many are given a chance to participate and OCA meetings don't become **one** person's meeting every week.

OCA meetings are run similar to other 12 Step meetings. The format allows for people to speak without **Cross-conversation**. This is important so that the individual sharing will not receive advice s/he may not want and will instead be heard without someone else chiming in. Yes, sometimes people will say "yeah, me too;" but **Crosstalk** is discouraged. We also suggest a 3-5 minute time limit for individual sharing at a meeting. This allows everyone who wants to speak to speak without running over the 1-1 1/2-hour meeting time. It also prevents anyone from dominating the discussions.

Most of our meetings welcome family members as well. But OCA is for people with OCD! Family members cannot lead meetings and even new people with OCD cannot lead until they have been coming regularly for three months or longer. This protects our primary purpose of helping those with OCD and keeps our focus on the 12 Step program

Now what can you do? If OCA is not in your area, visit other 12 Step programs (Emotions Anonymous, www.emotionsanonymous.org or CoDependents Anonymous, www.codependents.org). See what 12 Step meetings can offer. It is suggested that you visit at least six meetings with an open mind. Perhaps, you may like

what you hear and then want to start an OCA meeting in your area.

One of the things 12 Step programs talk about is humility and acceptance of our position in life. Delusions of "specialness" either positive or negative just don't work. We need to be one of many on this planet. But I **can** say that OCA is special. Our track record is unmatched in the OCD arena. Many of our meetings have been running for years.

Lastly, I would like to mention **Family Recovery** from OCD. While family members are welcome to sit in on most OCA meetings - family and friends living with OCD need a place for themselves most of all! In my book, *OCD - A Survival Guide for Family and Friends*, I focus on family recovery. At some point, the family needs to look at how it has been affected by a member's OCD. I suggest that family groups are a good idea. At them, family members can learn how to heal themselves instead of trying to fix their loved one's OCD.

From our humble beginnings when the OCA was viewed with skepticism, we have grown into an international network of meetings. To find out more about OCA and the location of meetings, you can visit the OCA's web site, <http://members.aol.com/west24th>, or call 516-739-0662. The OCA's mailing address is P.O. Box 215, New Hyde Park, NY 11040.

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Research Di

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

This Research Digest presents recent articles on trichotillomania (TTM). Although classified as an impulse control disorder, trichotillomania has similarities to OCD, is often comorbid with OCD, and many consider it an OC spectrum disorder. In the DSM-IV, the American Psychiatric Association defines TTM as:

1. Recurrent pulling out of one's hair resulting in noticeable hair loss.
2. Increasing sense of tension immediately before pulling out the hair.
3. Pleasure, gratification, or relief when pulling out the hair.
4. Not better accounted for by another mental disorder and not due to a general medical condition (e.g., a dermatologic disorder).
5. Results in substantial distress and/or interferes with functioning.

Trichotillomania: impact on psychosocial functioning and quality of life

Behaviour Research and Therapy, 43:869-884, 2005, G.J. Diefenbach, D.F. Tolin, S. Hannan et al.

This study looked at the impact of hair pulling on psychosocial functioning of 28 patients with TTM. These patients were compared to 28 patients with anxiety and mood disorders without TTM and to 28 community volunteers without psychiatric diagnoses. Individuals with TTM reported higher levels of depression than individuals without hair pulling problems and reported comparable levels of distress to individuals with other psychiatric disorders. Additionally, patient interviews indicated common and wide-ranging impairments for individuals with TTM. Low self-esteem and problems with grooming, physical health, social relationships, recreational activities and work performance were reported. These results highlight the emotional suffering associated with TTM and the need to improve the clinical care of TTM patients.

Severe obsessive-compulsive disorder with and without comorbid hair pulling: comparisons and clinical implications

Journal of Clinical Psychiatry, 66:864-869, 2005, S.E. Stewart, M.A. Jenike and N.J. Keuthen

Prevalence of chronic hair pulling was evaluated in 154 severely ill OCD patients at an intensive OCD residential treatment program (combined program of McLean Hospital and Massachusetts General Hospital). The presence of hair pulling, rather than trichotillomania, was investigated based on concerns that TTM diagnosis is too restrictive and differences between chronic hair pulling and TTM may represent symptom severity rather than different disorders. Of these OCD patients, 18.8% (N=29) reported any hair pulling, 15.6% (N=24) had moderate to severe hair pulling, and 7.8% (N=12) had severe hair pulling comparable to a TTM diagnosis. Hair pulling was more common, nearly one in every five patients, than reported in earlier studies. Patients with moderate to severe hair pulling were more likely to be women, more likely to have a tic disorder, and had an earlier age of onset of OCD. Additionally, these patients had fewer contamination obsessions and checking compulsions. It is interesting that those with hair pulling were significantly more likely to have tics, particularly motor tics, than OCD patients without hair pulling. Possibly TTM may be more closely related to tics than to OCD with hair pulling being similar to an atypical motor tic. In conclusion, hair pulling is very common in severe OCD. Women and early-onset OCD patients appear more vulnerable to developing it. Also, OCD patients experiencing tics are at an increased risk for hair pulling and vice versa.

Obsessive-compulsive disorder and trichotillomania: a phenomenological comparison

BMC Psychiatry (online journal), January: 1-10, 2005, C. Lochner, S. Seedat, P.L. du Toit et al.

Similarities and differences between OCD and TTM are discussed using data from a large comparison study of 278 individuals with OCD and 54 individuals with TTM. Sex ratio differed (predominantly females had TTM) and there was an equal male/female ratio for OCD. Patients with TTM had an earlier age of onset. Patients with OCD had a higher comorbidity of other disorders. OCD patients had significantly more lifetime disability, reporting greater impairment in work-related functioning, family functioning, daily activities and recreational activities. For women,

OCD and TTM symptoms were equally likely to worsen during menstruation. However, OCD onset or worsening was more likely to occur with pregnancy. Regarding treatment, fewer TTM patients reported responding to cognitive-behavioral therapy or serotonin reuptake inhibitor drug therapy. Researchers conclude that despite some overlap, there are significant differences between OCD and TTM.

Untreated trichotillomania and trichophagia: surgical emergency in a teenage girl

Psychosomatics, 46:362-366, 2005, K. Salaam, J. Carr, H. Grewal et al.

Ingesting hair (trichophagia) can cause trichobezoars (hairballs) to form in the stomach or intestines. It has been estimated that 5% to 18% of individuals with TTM ingest hair. Symptoms of trichobezoars include abdominal pain, nausea, vomiting and abdominal mass. This report describes the diagnosis and surgical removal of a large trichobezoar (3 pounds) in a 16-year-old girl. Despite being aware that swallowing hair could lead to medical problems, she was unable to stop on her own.

Hair apparent: Rapunzel syndrome

American Journal of Psychiatry, 162:242-248, 2005, A.S. Frey, M. McKee, R.A. King et al.

Rapunzel syndrome refers to trichobezoars that in appearance resemble a tail, extending from the stomach to the small intestine. Although rare, the formation of trichobezoars is a serious complication of TTM. On a routine physical exam, a pediatrician detected a stomach mass in a 7 year-old girl. She did not have physical symptoms, such as pain, nausea or vomiting, and she denied pulling or eating her hair. The trichobezoar was surgically removed. Based on the length of hairs ingested, it was determined that the child ingested both her hair and her mother's hair. This is an unusual case, for although she had chewed on her hair when she was three, her family was unaware of recent TTM.

igest

A controlled evaluation of acceptance and commitment therapy plus habit reversal for trichotillomania

Behaviour Research and Therapy, 2005 article in press, D.W. Woods, C.T. Wetterneck and C.A. Flessner

Acceptance and commitment therapy (ACT) consists of strategies to increase a person's ability to experience uncomfortable thoughts and feelings, such as a willingness to tolerate the urge to pull hair. Habit reversal training (HRT) is a behavioral therapy approach, which includes awareness training, competing response training and social support. Here, a combined ACT and HRT treatment of TTM delivered in 10 sessions was compared to a waiting list control group (patients waiting for treatment). Twenty-five participants with TTM (12 treatment and 13 waiting list) completed the trial. Compared to the waiting list group, the ACT/HRT group had a significant reduction in hair pulling severity, impairment ratings and hairs pulled, along with significant reductions in experiential avoidance and both anxiety and depressive symptoms. Reductions generally were maintained at a 3-month follow-up. Decreases in experiential avoidance and greater treatment compliance were significantly associated with reductions in TTM severity, implying that targeting experiential avoidance may be useful in the treatment of TTM.

Behavioural treatment of trichotillomania: two-year follow-up results

Behaviour Research and Therapy, 2005 article in press, G.P.J. Keijsers, A. van Minnen, C.A.L. Hoogduin et al.

Trichotillomania-related symptoms were evaluated in 28 patients with TTM treated with a brief manual-based behavior therapy (BT) based on habit reversal strategies. Patients were evaluated before and after BT, and at a 3-month and 2-year follow-up. Immediately after BT, TTM and depressive symptoms had decreased considerably. High relapse rates were found at follow-up. Better long-term response (not relapsing) was associated with lower pre-treatment levels of depressive symptoms and with complete abstinence from hair pulling immediately after treatment. Symptom-free patients after completion of their BT reported fewer TTM symptoms 2 years later. One implication of this study is that TTM treatments should be continued until patients have completely

stopped pulling. Additionally, researchers compared improvement in ability to resist pulling to the urge to pull. In contrast to their expectations, the urge to pull scores decreased as easily as the ability to resist pulling.

Pharmacological strategies for trichotillomania

Expert Opinion on Pharmacotherapy, 6:975-984, 2005, K.H. Walsh and C.J. McDougle

This article reviews studies on medication treatments for TTM. Few medications have been thoroughly studied in large groups of patients. Currently, no medication has been shown in multiple studies to reduce hair pulling in most patients, nor has a medication been shown to prevent relapse. Reviewers propose guidelines for treating TTM. First steps should include education regarding TTM, followed by treatment of any co-occurring dermatological and psychiatric conditions. First-line treatment for TTM should be behavioral, using habit reversal therapy. Additionally, patients should learn high-risk settings (situations often associated with hair pulling). Often, simple recording of hair pulling may help patients who are using medications only. If medications are used, selective serotonin reuptake inhibitors (SSRIs) appear the safest and best established choice. Positive response to SSRIs has not been consistent in the literature. Drug trials should reach higher doses and be tried for at least 13 weeks, as some studies have reported late responders. Patients who do not respond adequately to SSRIs should try clomipramine, neuroleptics or augmentation of an SSRI with a neuroleptic. Lithium augmentation is a consideration for patients with mood disorders.

Escitalopram treatment of trichotillomania

Presented at the American Psychiatric Association Annual Meeting, Atlanta, GA, May 21-26, 2005, K.M. Gadde, M.S. Foust and H.R. Wagner

Results from an open trial of escitalopram (Lexapro) treatment of TTM were reported. Twelve patients completed 12 weeks of treatment with escitalopram, doses ranging from 10 to 30 mg/day. Significant improvement occurred for 8 patients, with significant improvement defined as at least 50% decrease in symptoms.

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For more information, contact OCF Deputy Director, Jeannette Cole, at (203) 401-2069 or e-mail her at: cole@ocfoundation.org

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"The BTI without a doubt was the best professional development event that I have ever attended. All faculty were extremely knowledgeable, accessible, and agreeable interpersonally. I learned a great deal and feel that both my OCD patients and I have benefited quite a bit."

BTI Attendee

A Personal Perspective: The 12th Annual OCF Conference in San Diego

by **Herbert L. Gravitz, Ph.D.**
Santa Barbara, California

For three bittersweet days in late July of 2005, hundreds of intrepid souls ventured to the Town and Country Resort & Convention Center in San Diego, California, and were exposed to state-of-the-art knowledge regarding OCD and OC spectrum disorders. The attendees, a diverse group of travelers, came to end the denial, to learn, to share, and to support each other's triumphs over OCD. They were there to acknowledge the pain and celebrate the challenge of living with OCD, an illness of unrelenting negative thoughts and unsuccessful repetitive behaviors to manage them.

For many attendees, just getting to the conference was not only a huge hassle and effort but also an ordeal to be endured. It was also a major event and a clear victory for many OCD sufferers. Schedules and routines had to be changed; hard for anyone, let alone someone with such a fearful view of the world as someone with OCD. Compassion-fatigued family members surmounted the exhaustion from a life of illness, trauma, and stress to attend too. All the fine-tuning and adjustments, the last minute changes and stumbling blocks required to get there made it difficult or impossible for some. For those who didn't make it this year, perhaps next year you will come to Atlanta, Georgia.

For all those who made it to the conference this year, I salute your persistence and commitment. Your presence exposed the three great myths about OCD: one, that it is rare; two, that it is caused by emotional trauma; and three, that it is hard to treat. We now know that OCD is one of the most common psychiatric disorders with millions of primary sufferers, those with the disorder, as well as secondary sufferers, family members and loved ones. There is now abundant scientific evidence pointing directly to OCD as a neuro-chemical and biological disorder that is responsive to effective treatment.

For three days, the sheer presence of the conferees at the conference confirmed that the primary sufferers and the secondary sufferers were officially "in recovery" from what could be crippling circumstances. OCD can destroy not only the life of the individual but also the lives of his or her loved ones. Disconnecting family members from each other, OCD can shatter the family because the trauma of OCD can take the "us" and the "we" out of family living. Yet, countless souls choose to live life no matter how difficult and use their minds to change their brains, learning that they

don't have to believe everything they think. As one person said: "Thought happens."

There was a rich variety of presentations. More than 80 workshops addressed the needs of people with OCD of all ages as well as their families and the professionals who serve them. Participants had the opportunity to observe individuals and families well into recovery and others who were just beginning the journey, discovering that OCD can be an illness worth surviving for a life worth having. Because the family is often the last, and sometimes only bastion of help, especially as government funds for mental health services continue to shrink, it is even more difficult for primary sufferers and secondary sufferers to get the kind of treatment they need and deserve.

Like many excellent conferences, it may have raised as many questions as answers, serving as a source not just to get solutions but also to learn the right queries to pose. An enthusiastic group, the attendees, had as much to say and, sometimes more, than the speakers, who provided many opportunities for people-to-people exchanges.

In this atmosphere of freedom and choice, a great deal of joy and hope were evident in the conference rooms. Frequent laughs of recognition punctuated the silence as speakers mirrored the thoughts and feelings of participants. On so many occasions, I witnessed the greatness of those there – their bravery, courage, desire to learn and develop, and their overcoming obstacle after obstacle, first by coming to the conference and then by staying and refraining one more time from a compulsion or ritual.

I saw many discover and struggle with the transition zone, or the space between accommodation to the illness and holding loved ones accountable. Denial was shattered in room after room of fellow sufferers. We saw that in early stage recovery FEAR is an acronym for False Evidence Appearing Real, while in late recovery FEAR is Face Everything And Recover.

It was surprisingly easy to connect with people, including the presenters. There were many opportunities for new relationships to be established and old relationships rekindled. There were the old timers, the founding fathers and mothers, people like Dr. Jack Rachman who gave an enlightened and compassionate view of the courage of the family. He gave the family an appropriate place of importance

in the course and outcome of OCD.

As the context in which the major interactions of life occur, I have long thought that the family is the most underutilized resource for OCD. Recent research has shown that families of sufferers of social phobia and agoraphobia, many of whom may have OCD or another of the OC spectrum disorders, play a role in healing and recovery.

While it was repeatedly emphasized that the only person you can change is yourself, the importance of the family was underlined. The family, with all its shortcomings and strengths, can half the bitterness of life and double its sweetness. Psychologist Paul Pearsall humorously reminds us of the importance of family in his book, *The Last Self-Help Book You'll Ever Need*. "A family," he writes "is nothing more than a group of people irrationally committed to one another's welfare. Being a good family member and being able to enjoy living every day with a group of flakes and failures. A good family is a group willing to stick with you when most sane and discerning people would vote you out." There is always a bit of truth in humor.

Like a good family, the OCF took on a gallant challenge, and it produced a smashing success for most of the attendees. It boldly asserted in its conference brochure: "Anything you need to make this happen – just ask us. We are here to help." Ever attentive to the needs of all conference members, they had good food (except when there was a run on lunch the first day), good company, and good information. There were special opportunities for children, teens and young adults, as well as adults. There was an Art Exhibit and bookstore to help pass along information. There was even an opportunity for attendees to give blood for genetics research, the ultimate exposure for some.

In summary, the conference was an incredibly moving and powerful experience. It was an honor to be there to witness the personal and family empowerment conferees displayed. It was a reminder that we can face virtually any adversity – and triumph. Thank you, OCF. You delivered on your commitment. You showed that it is never too late to get better, and that it is never too late to be a family. You showed that OCD is a loss worth enduring and life worth living. And you showed that we never need to be alone anymore. Because of conferences like this, we have more choices now.

Dr. Gravitz is the author of "Obsessive Compulsive Disorder: New Help for the Family," and practices in Santa

BEYONDBEAUTY Dinner Raises Money for Genetics Research

The following is an interview with Linda Marshall, secretary of the James E. Marshall OCD Foundation, and the driving force behind the beyondBeauty inaugural fund-raising dinner.

NEWSLETTER: As secretary and a director of the James E. Marshall OCD Foundation, you recently gave the Obsessive Compulsive Foundation a check for \$31,307.64 to help fund genetics research. What is the James E. Marshall OCD Foundation? When was it started and what is its mission?



The Marshall Family, from left to right, John Marshall, Linda Marshall, Jennifer Marshall, Jady Franklin, and Ryan Marshall.

MARSHALL: The James E. Marshall OCD Foundation was started to honor my son, Jim, who lost his battle against OCD. He couldn't see a light at the end of the tunnel. We started the foundation in 2002 because in the last conversation I had with my son the day before he died, he said, "Mom, I want to make a difference." We are committed to seeing his wishes fulfilled. Our mission is to help fund genetic research and education about this terrible illness.

NEWSLETTER: What kind of fund raiser did you put on to raise the money that was contributed to the OCF Research Fund?

MARSHALL: We held an intimate dinner to honor two Cosmetic Industry icons, Mr. Edward Kavanaugh, president of the Cosmetic, Toiletry, and Fragrance Association and Annette Green, the former president of the Fragrance Foundation. This is a disease that directly affects our industry. People with BBD look to our products to solve problems they can never solve, so we named the event beyondBeauty. We want to help beyond the typical beauty issues.

NEWSLETTER: You set up a committee to help with the dinner, who was on it and how did you recruit them?

MARSHALL: The committee was made up mainly of industry leaders, beauty editors, and members of the OC Foundation. Most of the people on the committee are friends and business associates and they shared the grief that my family and I have been through. As knowledge of the illness became more apparent, many realized that they had family members that are struggling.

NEWSLETTER: How did you get the Cosmetic and Fragrance Industries to help you put on the dinner and to support it?

MARSHALL: I had 100% support from everyone I asked. The Cosmetic Industry is a very caring and generous industry. They are involved in many worthwhile benefits. Aside from the Look Good, Feel Better Foundation benefit that raises money for women recovering from cancer, this is the first fund raiser for something that touches all of us in one way or another. It could be at the cosmetic counter, an employee, or a family member.

NEWSLETTER: Who were the honorees at the beyondBeauty dinner? How were they picked?

MARSHALL: The honorees were chosen because they have served our industry for over 25 years and were admired and respected by the entire industry. Annette Green had already retired and Edward Kavanaugh retired in March of 2005. They are also friends and are a real support to my family and me.

NEWSLETTER: How did you promote the dinner and who was invited to attend?

MARSHALL: Once a date was set we sent out "Save-The-Date" cards, e-mails, and invitations. I also made calls and sent out faxes. The committee also made calls. It was also promoted through *Beauty Fashion* and *Cosmetic World*, trade magazines.

NEWSLETTER: How many people attended the dinner? Where was it held? How did you get the venue?

MARSHALL: We used the Union League in New York City because it's an elegant yet personal space. It was recommended by John Ledes, editor and publisher, of *Cosmetic World* and *Beauty Fashion*. There were 230 people in attendance.



Enjoying themselves at the beyondBeauty dinner are Terry Murphy, OCF Board Member; Joy Kant, President, OCF Board of Directors; Linda Marshall, Secretary and Director, James E. Marshall OCD Foundation; Janet Emmerman, OCF Board of Directors; Dr. Michael Jenike, Professor, Harvard University Medical School; Patricia Perkins, Executive Director, OCF; Jennifer Marshall, President, James E. Marshall OCD Foundation; and John Marshall, Vice President, James E. Marshall OCD Foundation.

NEWSLETTER: You had sponsors and patrons for the dinner, who were they and how did you recruit them?

MARSHALL: We did have sponsors and patrons and they weren't recruited, they signed up based on the different options they were offered. Proctor and Gamble, Coty, IFF, Givaudan, Avon, L'Oreal, Liz Clairborne, Wessel Fragrances, all took the more expensive tables.

NEWSLETTER: How did you educate the attendees about OCD?

MARSHALL: I sent out an article on OCD each month for three months prior to the event – I sent out the OC Foundation Newsletter. The night of the event Dr. Michael Jenike from Harvard spoke about OCD.



Linda Marshall; Dinner Honorees, Annette Green and Edward Kavanaugh; and Jennifer Marshall.

NEWSLETTER: You had a tribute book at the dinner. How did you put it together? Who worked on it? Were you able to get its printing donated?

MARSHALL: The tribute book was put together by several members of the committee and John Ledes did all the final

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Book Review

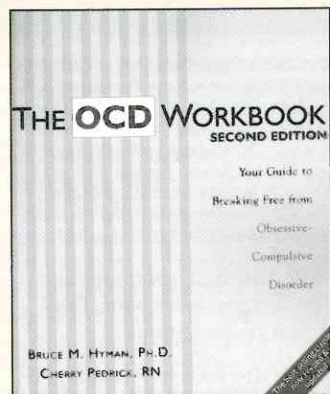
The OCD Workbook, Second Edition

By Bruce M. Hyman, Ph.D. and Cherry Pedrick, R.N.

Book Review by Patricia M. Perrin, Ph.D.

**OCD and Anxiety Treatment Center
Houston, Texas**

The OCD Workbook, Second Edition, by Bruce Hyman, Ph.D., and Cherry Pedrick, R.N., is



an outstanding, practical, very readable step-by-step guide to treating obsessive-compulsive disorder (OCD). It continues to fulfill the

missions of the first edition of being an accessible guide for sufferers of OCD and their families and a valuable resource for professionals. The authors have succeeded in preserving the basic original text, but they have expanded their discussion in numerous areas throughout the book. They also added a welcome chapter on mindfulness, a topic that is not always easily grasped.

There is a shortage of therapists who know how to treat OCD, and there are a lot of sufferers looking for help. So it makes sense that Bruce Hyman, Ph.D., a seasoned clinician treating OCD, and Cherry Pedrick, a nurse and an OCD sufferer, have come together to write a book that meets these mutually compatible needs. Their almost conversational writing style takes academically sound information and puts it in layperson's terms. Where jargon is used, it is defined. Concepts are explained in the context of patients' stories which illustrate the particular OCD symptoms or treatment approach being discussed. This process provides nearly effortless learning in terms of making concepts alive and understandable.

The structure of the book is definitely user friendly. It starts each chapter with well-researched text on a subject, followed by easy-to-grasp bullet point lists, checklists, or self-assessment tools. In true workbook form, there are many fill-in sections and tables that can be used, e.g., to identify one's own compulsions and obsessions or faulty beliefs or to develop one's own

hierarchies of exposure items (for use in exposure and response prevention [ERP] therapy). Detailed examples are provided using case studies. "Keys to Breaking Free" throughout the book lend helpful hints, fine tune treatment suggestions, and offer encouragement. The book is practical, practical, practical!

It is no wonder that I often find myself turning to *The OCD Workbook* as a reference for patients. Just the other day, a patient with obsessions about molesting children was struggling with doing imaginal exposure to these thoughts. She was concerned that she might enjoy accidentally bumping into a child (magical thinking) or that intentionally thinking the thoughts might be evidence that she is a child molester (thought-action fusion, persistent doubting). Realizing that her faulty beliefs were interfering with her doing ERP, I referred her to the chapter on "Challenging Your Faulty Beliefs." Hence, *The OCD Workbook* provides tools that can support therapists, too.

The book is arranged in four parts. Part I consists of three chapters. They include an overview of what OCD is, the influence of genetics, and its neurobiology. The first chapter sets the tone discussing symptoms with which the sufferer can identify. Ten cases are given, which are referred to throughout the book. Cases include Cherry's own story, primarily about checking. Her self-disclosure is admirable and engaging. Other cases include individuals with contamination fears, "just right" OCD, "hit and run" OCD, ordering, hoarding, fears of harming, and repeating rituals.

Chapter 2 includes a checklist of obsessions and compulsions as well as an excellent section on the neurobiology of OCD. Chapter 3 provides an overview of types of treatment available, emphasizing those with a proven track record: cognitive-behavior therapy (CBT) and medication.

Part II includes six chapters on assessment and treatment. Chapter 4 gives a thorough description of the CBT called exposure and response prevention therapy, the core of the self-directed program. This chapter explains the key behavioral concepts of habituation and extinction, and how habituation results in the brain reappraising OCD messages. The section on dealing with fear of change reflects the authors' compassion for those who experience fear when first trying ERP therapy. Guidelines are included for family members who want to coach someone with OCD.

Chapter 5 focuses on the self-assessment of the individual's obsessions and compulsions. Chapter 6, "Your Intervention Strategy," gets down to the nitty-gritty of designing ERP treatment using a step-by-step plan. It provides examples of hierarchies of triggers for specific fears, based on cases presented in Chapter 1. Readers are also given a choice of either a "fast-track" approach to doing exposures or a "gradual method," which involves ritual delay.

Chapter 7, "Imaginal Exposure," is well written and full of sample imaginal exposure narratives. It is especially valuable to those therapists who are comfortable with in vivo exposure techniques but who are unfamiliar with imaginal exposure techniques. The section on dealing with common problems with imaginal exposure is also helpful.

Chapter 8, "Challenging Your Faulty Beliefs," is about identifying and challenging cognitive errors often made by people with OCD. It gives examples of 12 faulty beliefs (e.g., overestimating risk, all-or-nothing thinking, thought-action fusion, intolerance of uncertainty, etc.) and provides a table of thoughts and their corresponding faulty beliefs. As noted above, it can help to remove barriers to proceeding with ERP.

Chapter 9 is a refreshing, new chapter about mindfulness. Mindfulness aims to use nonjudgmental awareness to decrease emotional reactivity to the thoughts, feelings, and impulses that contribute to the emotional distress of OCD. Mindfulness is presented as an adjunct to ERP, not a replacement. It encourages readers to cultivate an "impartial spectator" within themselves in order to observe OCD thoughts with detachment.

Part III includes seven chapters on special forms of OCD. The chapter on "pure obsessions" is excellent. Although this term is in the literature, those who report obsessions without behavioral rituals do have cognitive rituals, which the authors note. Some clinicians prefer calling these individuals "primarily obsessional," to make that point. This chapter emphasizes the fact that obsessionals "are not in danger of acting out their unwanted horrific thoughts," nor are they in danger of "snapping" and acting on their thoughts of harming. The authors also clearly describe how an intrusive thought becomes an obsession.

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From the President

(continued from page 1)

Conference, and our web site have been a way to keep you up-to-date.

As a consumer, you have choices to make in determining the treatment that is best for you. You should begin by picking a mental health provider who will give you a definitive diagnosis. Before you decide on a professional, you may want to order from the Foundation, the recently published pamphlet, "How Do I Know If My Therapist Can Treat OCD." The author, Lisa Bertman-Pate, Ph.D., explores the questions that you may want to ask the treatment provider before deciding to work with him or her. In addition, Dr. Jenike has written an article entitled "How To Select A Behavior Therapist" which was published in the Spring 2005 OCD Newsletter.

One of the treatment approaches that has been in the forefront for years has been cognitive-behavioral therapy. The Foundation has provided Behavioral Therapy Institutes for therapists who want to learn how to use this technique in their practices. During 2005, we held one in Philadelphia; and in 2006, we will have one in Los Angeles. Thirty treatment providers attended the Philadelphia BTI. We are expecting a similar number to attend the BTI in Los Angeles.

In many cases, CBT and other forms of therapy do not provide enough relief and medication should be explored to augment the treatment. Even then, not everyone responds to medication. As we know, OCD is a biochemical disorder and what works for one individual may not in fact work for another. I have seen medication help my son, but I have also heard of incidences when it has not been helpful.

We know that finding a treatment plan that helps you manage and reduce your rituals and your compulsions, or for that matter gets rid of them, is an arduous task, one that may take years to accomplish. Often OCD waxes and wanes, throwing you into a false sense of belief that you are cured. As of now, we know of no cure. We do know how to manage the effects of the disorder, recognizing obsessive thought processes for what they are.

The Foundation supports and welcomes researchers who are working to find "Effective Treatment for Everyone." We also encourage their collaboration in finding the genetic link to OCD. I truly believe that in our lifetime, thanks to these researchers, there will continue to be advances that help those who live with OCD.

Best Regards,

Joy Kant
President
OCF Board of Directors

Fear and Courage

(continued from page 1)

longed time and prevented from leaving the situation, they became less scared.

"Therapists were scared to do it with patients," Dr. Rachman said. But Dr. Meyer, a former World War II fighter pilot shot down in France and taken as a prisoner of war, was willing to take a risk. In 1966, he began ERP therapy with two hospitalized patients. One of them incapacitated by fears of disease and dirt spent most of the day cleaning. She had not been helped by shock treatment, drugs, or supportive therapy and was being considered for surgery, according to Dr. Rachman. Dr. Meyer, and later a nurse, exposed her to objects that triggered her anxiety and prevented her from carrying out her cleaning rituals. They turned off the water in her room and severely limited her access to cleaning agents.

"She was very frightened at times but she managed to cooperate with treatment," said Dr. Rachman. After four weeks of intensive therapy, she was less anxious and, after eight, even less so. Her compulsive cleaning dropped to tolerable levels.

Meyer's second patient was incapacitated by recurrent, disruptive blasphemous thoughts about sex. It took her up to six hours to get dressed each day. Shock therapy, drugs, eleven years of psychoanalysis and then psychosurgery all had failed her; and she was being considered for a second surgery.

Instead, she underwent this new behavior therapy. Her anxiety was heightened through exposure to triggering items and imaginal scenes while she was prevented from performing any anxiety-reducing behaviors. After nine weeks of difficult and distressing intensive therapy, her OCD symptoms dropped to manageable levels. Neither was cured; but both regained normal lives.

"The consequence of Victor Meyer's success was spectacular. He had broken the ice," said Dr. Rachman.

Over the decades, clinicians and researchers have continued to study and experiment with ways to improve ERP techniques and better understand how to help people with OCD.

Recognizing the importance of cultivating courage in OCD patients, Dr. Rachman and his colleagues realized

they needed to understand where such courage comes from and how to encourage and enhance it. They decided to interview people who needed courage to do their jobs, such as, fire fighters, police, and security people. Ultimately, they chose bomb disposal operators in the United Kingdom during a time of great conflict with the Irish Republican Army.

In a 10-year period, the operators took 31,000 calls, two-thirds of which were hoaxes, he said. But they entered each situation knowing their lives could be in danger, and that a mistake could be fatal. The researchers wondered how the bomb disposal squad was chosen, assuming courage was a prerequisite. Instead, they learned, all military personnel were expected to do the job once they received extra training.

The operators' fear decreased as their confidence in their abilities increased the researchers found. From 60 percent confidence before training, their confidence increased to 90 percent after training, and up to around 97 per cent once they had succeeded in one or more disarmaments.

"This had obvious application to psychological treatment, including exposure and response prevention," said Dr. Rachman. "In the course of this treatment [for OCD], I was struck by how patients' lives were being damaged, how they were extremely frightened people. And our treatment required coming in contact with the sources of their greatest distress. We expected them to willingly be exposed to them day after day."

The researchers were impressed by patients' resilience, and by how quickly they regained their composure after each exposure session. Researchers and clinicians continue to investigate new techniques, drawing on patients' courage and advancing cognitive-behavioral therapy, to provide even more effective treatment, Dr. Rachman said.

People with OCD, despite their terror, can draw on their innate courage and fight back. As they succeed, their success will boost their confidence to continue the fight. Clinicians, for their part, must promote courageous behavior in their patients by helping them draw on those resources and sustain the effort.

"All people are capable of courage," concluded Dr. Rachman, "including the most fearful of us."

Bulletin Board

(continued from page 2)

ipants for a treatment research study to reduce the symptoms associated with Tourette Syndrome or Chronic Tic Disorder. To be eligible, you must: have Tourette Syndrome or Chronic Tic Disorder, be at least 16 years of age or older, be able to commute to the Boston area, be able to participate for 12 weeks.

If you are interested in this study and believe you are eligible, please contact Dieu-My Phan at (617) 724-4354 or email her at dphan@partners.org

BODY IMAGE TREATMENT RESEARCH STUDY

Do you dislike the way any part(s) of your body (for example, your skin, hair, nose, eyes, and genitals) look?

Do you think about your appearance for more than one hour per day?

Do you engage in any behaviors intended to check on, hide, or fix your appearance (for example, mirror checking, comparing yourself to others, excessive grooming behaviors)?

Or do you avoid any places, people or activities because of your appearance concerns (for example, do you avoid bright lights, mirrors, dating, or parties)?

Do your appearance-related thoughts or behaviors cause you a lot of anxiety, sadness, or shame?

Do you have problems with your work, school, family, or friends because of your appearance concerns?

In case you answered any of these questions with "yes" and if your primary problem is not related to unusual eating habits or weight concerns, you might be eligible to participate in a study at the Massachusetts General Hospital (MGH). If you qualify, you will receive the following: Diagnostic evaluation at no cost and medication treatment at no cost. You will also be asked to fill out some questionnaires assessing body image symptoms, anxiety and mood. If you are interested in participating or would like to get further information, please call Kara Watts at (617) 643-3079 at the Massachusetts General Hospital (MGH), Body Dysmorphic Disorder Clinic, or email her at klwatts@partners.org.

DO YOU SUFFER FROM OBSESSIVE-COMPULSIVE DISORDER?

Do you have unwanted thoughts that are

hard to control? Do you have any behaviors that you have to do again and again and cannot resist doing? Are you diagnosed with obsessive-compulsive disorder (OCD)? Do you have problems with your work or social life because of this?

Dr. Sabine Wilhelm of the Massachusetts General Hospital OCD Clinic and Research Unit is seeking participants for a research study on the use of a medication in combination with behavior therapy to reduce the symptoms associated with obsessive-compulsive disorder (OCD). To be eligible, you must: have OCD, be between 18 and 65 years old, be able to commute to the Boston area, be able to participate for 10 weeks, not be pregnant or breastfeeding. If you are interested in this study and believe you are eligible, please contact Dr. Ulrike Buhlmann at (617) 726-5374 or email her at ubuhlmann@partners.org.

DO YOU HAVE OBSESSIVE-COMPULSIVE DISORDER?

Do you still have symptoms? We are conducting a research study of an investigational supplemental agent for individuals from 18-65, who have been treated for obsessive-compulsive disorder but still have symptoms. All study-related procedures and evaluations are provided at no expense. Reimbursement for participation available. For more information and to find out if you are eligible for this study, please call:

The Nathan Kline Institute
Outpatient Research Program
Orangeburg, NY
Call Joanna (845) 398-2183

RESEARCH STUDY ON THE GENETICS OF OBSESSIVE-COMPULSIVE DISORDER (OCD)

Do you have obsessive-compulsive disorder? We are doing a research study to find genes associated with OCD. We are looking for children and adults with OCD and their family members. Family members are welcome to participate whether or not they now or in the past have experienced OCD symptoms. Family members who can participate include any biological relatives of the person with OCD, such as parents, siblings, children, grandparents, aunts, uncles and cousins.

Your involvement in this study and any information given will be kept confidential. Participants will be offered a modest cash honorarium to compensate for time spent participating in this study. This study is being conducted by Drs. Paul Arnold,

James Kennedy and Peggy Richter, at the Centre for Addiction and Mental Health in Toronto, Ontario, Canada, and is part of a larger project including centers in Michigan and Florida. Our research was partially supported through the generosity of the OCF in the form of an OCF Research Award.

For more information, please contact our research coordinator, Eliza Burroughs:
Tel: 416-535-8501 ext.4829;
Email: eliza_burroughs@camh.net
Address: 250 College Street
Toronto, Ontario, M5T 1R8

UNIVERSITY OF FLORIDA RESEARCH STUDY

Do you repeatedly check or arrange things, have to wash your hands repeatedly, or maintain a particular order? Do unpleasant thoughts repeatedly enter your mind, such as, concerns with germs or dirt or needing to arrange things "just so"?

If this sounds familiar, you may have a treatable problem called obsessive-compulsive disorder (OCD). Past research has found that a form of talk therapy, namely, cognitive-behavior therapy, is helpful in as many as 85% of people with OCD. Researchers at the University of Florida are interested in determining if adding a medication called D-Cycloserine improves the effectiveness of cognitive-behavior therapy in adults with OCD. [UF IRB approval # 539-2004]

To be eligible, you must be at least 18 years old. If you participate in this study, you will be randomly assigned, that is by chance as in the "flip of a coin," to receive either the study medication (D-Cycloserine) or a sugar pill in addition to being seen in therapy. The therapy will be held weekly (90 minutes each session) for 12 weeks (12 total sessions). There will also be nine psychiatric evaluations that take place. Three of these evaluations will be comprehensive and take about 2 1/2 hours each (immediately before and after treatment, and three months after treatment). Six will be short and take place once a week during therapy (25 minutes each). You are responsible for the cost of therapy. Study medication and the evaluations will be provided at no charge. Participants will also receive financial compensation for their time.

If interested, please contact Dr. Eric Storch at (352) 392-3611 or estorch@psychiatry.ufl.edu.

ARE YOU AN AFRICAN-AMERICAN SUFFERING FROM OCD?

Have you ever been diagnosed with Obsessive-Compulsive Disorder? Or have you suspected you may have it, experiencing hard to control, unwanted thoughts or irresistible, repetitive behaviors?

If so, and you ...

- * Are African-American
- * Are 18 years of age or older
- * Can read English
- * Grew up in the United States

We invite you to participate in a study with the University of Virginia. You just need to fill out an anonymous questionnaire by mail and answer a few questions over the phone and you will receive \$25!!

For more information or to sign up,

Contact Emily Magee at 814-937-9438 or by email at anxietystudy@peernom.org

A FAMILY RESEARCH PROJECT

Who? We are a research team from The Johns Hopkins Hospital who are interested in studying family functioning in different groups of children between the ages of 6-17 years.

What? To study family functioning of children and adolescents with Obsessive Compulsive symptoms and those without symptoms.

Where? In your own home. No hospital or school visits are necessary.

How? (Parent) A phone interview regarding your child's behavior and daily functioning as well as the relationship with your child. Paper and pencil questionnaires regarding aspects of family functioning.

(Child and adolescent) A phone interview regarding his/her behavior and daily functioning. Questionnaires regarding his/her relationship with you and his/her personality.

Compensation? Your child will be given a \$15 gift certificate to a book store in exchange for participation. This will be given after all questionnaires and interviews are completed.

How to Join this Research? Call us at 443-287-2292 or e-mail Marco Grados at MJGrados.jhmi.edu and let us know if you are interested in participating and when we can reach you.

Your participation will help us understand family functioning in children and adolescents with OCD.

Principal Investigator: March Grados M.D., M.P.H. RPN#

The Obsessive Compulsive Foundation 2006 Research Awards

"Call for Proposals"

Deadline for Submission

January 13, 2006

The Obsessive Compulsive Foundation invites investigators to submit grant applications for the 2006 OCF Research Awards.

Topics of Interest

The OC Foundation is committed to finding and promoting "Effective Treatment for Everyone with OCD." To further this mission the Foundation is interested in funding research into the brain, its chemistry, structure and functioning; basic neurobiology; the genetics of OCD; its epidemiology, as well as all aspects of OCD and the OC Spectrum Disorders that will lead to prevention and treatment advances.

Post-doctoral fellows are encouraged to submit proposals.

For more information on how to apply, contact Deputy Director Jeannette Cole at 203-401-2069 or at cole@ocfoundation.org

BEYONDBEAUTY

(continued from page 9)

editing and had it printed. We did not have anyone underwrite the printing – that's something we will do for the next event. We also want to get someone to underwrite the music and the decorations.

NEWSLETTER: The inaugural beyondBeauty dinner was a success. Do you intend to do another one?

MARSHALL: Yes, we are currently working on plans for another beyondBeauty event and our honorees will be Marc Pritchard, president, Global Cosmetics and Hair Coloring at Proctor & Gamble, and Steve Sadove, chairman/COO of Saks Incorporated.

NEWSLETTER: Why is it important for the James E. Marshall OCD Foundation to raise money for research into the genetics of OCD?

MARSHALL: It appears that OCD is genetic. Jim left a little son behind and I want to do everything possible to find answers so he won't have to suffer the way his daddy did and hopefully his children won't be affected.

NEWSLETTER: What advice would you give to someone who wanted to put on a fundraiser similar to beyondBeauty to raise money to support the OCF and its Research Program?

MARSHALL: I'm lucky to be part of an industry that cares about people and while very competitive in the market place really are very supportive when it comes to making a difference. I also am blessed with some celebrity friends that are willing to pitch in, such as Dionne Warwick, who was our Mistress of Ceremonies. Robert Wagner and his wife Jill St. John are on the James E. Marshall, OCD Foundation Board of Directors and they are very supportive. You could have auctions, bake sales, celebrity events like tennis or golf. I find that people like to be needed and help when the cause is worthy.

Linda R. Marshall is president of Elysée Scientific Cosmetics, Inc.

"Your Thoughts Revealed - Answers to Dr. Grayson's Challenge" will make its debut in the Late Fall issue of the OCD Newsletter

Affiliate News

(continued from page 4)

treatment of OCD, they can help members of their community learn to improve their quality of life and experience the joy and fulfillment that religious devotion can provide.

Contact: Ellen Sawyer, Executive Director, OCF of Chicago, esawyer@ocfchicago.org, or 773-880-1635.

Obsessive-Compulsive Foundation of Western Pennsylvannia (OCFW-PA) Update

As the Obsessive-Compulsive Foundation of Western Pennsylvannia enters its sixth year, we are more determined than ever to expand our services and to educate mental health professionals and the general public about OCD and "effective treatment for everyone." We continue to maintain a well-utilized web site and phone line as a local resource. We also provide newsletters to our members.

This year we are planning to give presentations to school-related groups based on "OCD in the Classroom" and hold a one-day conference to educate consumers and their families and to train interested therapists in ERP therapy. A survey will be sent out shortly to determine the types of workshops and seminars which are most likely to be of interest to mental health professionals in Western Pennsylvania.

This fall we are sending flyers about the three OCD support groups in the areas to local therapists so they can share the information with their OCD patients. We are also holding a fund raiser at Uno's Chicago Grill. We will get 20% of the total bill of anyone who eats there on our designated day and turns in our coupon.

Contact: Debbie Iannuzzi, President, OCFWPA, IAZZI@aol.com or 412-519-3826.

Obsessive Compulsive & Related Disorders Les Grodberg Memorial Lecture Series 2005 - 2006

Sponsored by the Greater Boston Affiliate of the Obsessive Compulsive Foundation
McLean Hospital, De Marneffe Cafeteria
Building, Belmont, MA 02478

The OCF of Greater Boston, in conjunction with McLean Hospital, presents a series of preeminent speakers in the field of OCD and related disorders. An informal social is held from 6:30 pm - 7:00 pm. Each presentation begins at 7:00 pm in Room 132.

November 1, 2005
Eating Disorders and OCD
Mary Ellen Crowley, Ph.D.
McLean Hospital

December 6, 2005
Psychopharmacology in Pediatric OCD

Daniel Geller, MD
Mass General Hospital

January 3, 2006
Sleep Disorders and OCD
Cindy Dorsey, Ph.D.
McLean Hospital

February 7, 2006
How to Manage OCD in the Classroom
Jeanne Straussburger, Ph.D.
Cambridge Hospital

March 7, 2006
OCD in the Workplace
Alan Siegal, LCSW
Bay State Medical Center

April 4, 2006
Family Coaching and OCD
Laura Ferrer, Ph.D.
McLean Hospital

May 2, 2006
Genetics Research and OCD
Evelyn Stewart, MD
Mass General Hospital

June 6, 2006
Self-Harm Obsessions and Compulsions
Deb Osgood-Hynes, Psy.D.
MGH/McLean OCD Institute

All lectures are subject to change without notice. Following each speaker presentation, there are several free self-help groups open to the public. For information on support groups please contact Denise Egan Stack at 617-855-2252. The groups will begin at 8:00 pm and run until approximately 9:30 pm in rooms 114, 115, 117 and 118. The identity of participants and content of group discussion must remain confidential. Furthermore, if desired, you may remain anonymous. We remind participants to be open and supportive to the views of all those who take part in the support groups.

Community Awareness Event Scheduled

The Central New York OCF Affiliate is making plans to host a Community OCD Awareness Event in the spring of 2006. It will be held on a Saturday in April at the local United Cerebral Palsy Center in Utica, NY. This will be the second such informational session that the CNY OCF has sponsored over the years. Advertisements will be placed in local newspapers, TV and radio.

We are working with pharmaceutical representatives who appear committed to providing assistance to our Board of Directors on this project.

The informational session will consist of a panel of local OCD treatment providers, addressing what OCD is, who it affects, treatment modalities, how to find treatment, etc.

Contact: Susan Connell, Secretary/Treasurer, CNYOCF, cynocf@dreamscape.com

The OCD Workbook

(continued from page 10)

Chapter 11 is a well-written chapter on scrupulosity, which includes religious obsessions as well as obsessions based on hypermorality and hyperresponsibility. Examples of useful in vivo as well as imaginal exposures are given. Chapter 12 may be the only chapter I have seen in any book devoted entirely to "Hit 'n Run OCD," which is useful. Chapter 13, on hoarding, delineates the cognitive errors involved and provides steps to eliminating clutter. All three are useful tools for working with these respective disorders.

Chapter 14 discusses pitfalls to be aware of in treatment, and it covers managing lapses and preventing relapse. Chapter 15 is about differences in how OCD shows up in children and terminology that helps in treating children. It discusses evidence that the onset of OCD is sometimes secondary to streptococcal infections. Common comorbid conditions in children are discussed: Tourette Syndrome and Attention Deficit/Hyperactivity Disorder.

Chapter 16, "OCD and Company," is informative about OCD spectrum disorders, which are sometimes comorbid with OCD. These include body dysmorphic disorder (BDD), which is characterized by preoccupation with a minor or imagined bodily defect; trichotillomania (TTM) or hair pulling; and skin picking. For the latter two, the treatment indicated is habit reversal training. A related, but more extensive, multimodal approach developed at the Behavior Therapy Center of Greater Washington is not mentioned.

Chapter 17 is a very important chapter for family members helping a person with OCD. It emphasizes the need for family members to take care of themselves. Chapter 18 discusses how to select a professional to help with OCD online and elsewhere. The Appendix includes an assessment tool, the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS), which measures the severity of one's OCD. The section on resources is thorough in that it provides book titles, mental health associations, and web sites.

Clearly, *The OCD Workbook, Second Edition* is a very valuable guide for OCD sufferers who want a self-directed program or who have no qualified professionals nearby. I wish to reiterate, however, that it is full of very thoughtfully designed tools and creative ideas that therapists will also find stimulating and helpful in working with OCD sufferers.

Compliance with Solicitation Regulations

The Obsessive Compulsive Foundation, Inc. ("OCF") is a Connecticut not-for-profit corporation. Its mission is to educate the public and professional communities about Obsessive Compulsive Disorder ("OCD") and related disorders; to educate and train mental health professionals in the latest treatment of OCD and related disorders; to provide assistance to individuals with OCD and related disorders, and their family and friends; and to support research into the causes and effective treatment of OCD and related disorders. The OCF's principal place of business is 676 State Street, New Haven, Connecticut 06511-6508. The information enclosed herein describes one or more of the OCF's activities. Your gift is tax deductible as a charitable contribution. Contributions received by OCF do not inure to the benefit of its officers, directors or any specific individual.

A copy of OCF's most recent financial report is available upon request and may be obtained at no cost by writing to OCF at P.O. Box 9573, New Haven, Connecticut 06535-0573 or by contacting its Executive Director at (203) 401-2074. If you are a resident of one of the following states, you may obtain information directly as follows: Florida: A COPY OF THE OFFICIAL REGISTRATION AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE FLORIDA DIVISION OF CONSUMER SERVICES BY CALLING TOLL FREE WITHIN THE STATE (800) 435-7352, OR (850) 488-2221 IF CALLING FROM OUTSIDE

FLORIDA. OCF's registration number in Florida is CH8507. Maryland: A copy of the documents and information submitted by OCF pursuant to the Maryland Charitable Solicitations Act are available for the cost of copies and postage from the Secretary of State, State House, Annapolis, MD 21401, Telephone (401) 974-5534. OCF's registration number in Maryland is 5015. Mississippi: The official registration and financial information of OCF may be obtained from the Mississippi Secretary of State's office by calling (888) 236-6167. OCF's registration number in Mississippi is C1143. New Jersey: INFORMATION FILED WITH THE ATTORNEY GENERAL CONCERNING THIS CHARITABLE SOLICITATION MAY BE OBTAINED FROM THE ATTORNEY GENERAL OF THE STATE OF NEW JERSEY BY CALLING (973) 504-6215. OCF's registration number in New Jersey is CH1461800. New York: A copy of the most recent annual report filed by OCF with the New York Secretary of State may be obtained by writing to Charities Bureau, 120 Broadway, New York, NY 10271, Telephone (518) 486-9797. OCF's registration number in New York is 66211. North Carolina: A COPY OF THE LICENSE TO SOLICIT CHARITABLE CONTRIBUTIONS AS A CHARITABLE ORGANIZATION OR SPONSOR AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE DEPARTMENT OF HUMAN RESOURCES, SOLICITATION LICENSING BRANCH, BY CALLING (919) 733-4510.

OCF's registration number in North Carolina is SL002059. Pennsylvania: A copy of the official registration and financial information may be obtained from the Pennsylvania Department of State by calling toll free, within Pennsylvania, (800) 732-0999. OCF's registration number in Pennsylvania is 15687. Virginia: A copy of the OCF's most recent financial statement is available upon request from the State Division of Consumer Affairs in the Department of Agriculture and Consumer Services. Washington: Additional financial disclosure information may be obtained by contacting the Secretary of State toll free, within Washington, at (800) 332-GIVE. OCF's registration number in Washington is 6363. West Virginia: West Virginia residents may obtain a summary of the registration and financial documents from the Secretary of State, State Capitol, Charleston, West Virginia 25305. REGISTRATION WITH A STATE AGENCY DOES NOT CONSTITUTE OR IMPLY ENDORSEMENT, APPROVAL OR RECOMMENDATION BY THAT STATE. THE OCF DOES NOT HAVE A PROFESSIONAL SOLICITOR. ONE HUNDRED PERCENT OF EVERY CONTRIBUTION IS RECEIVED BY THE OCF. DONATIONS WILL BE USED TO UNDERWRITE THE OCF'S PROGRAMS, ACTIVITIES AND OPERATIONS AS WELL AS FOR RESEARCH.

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