

Message from the President



Dear Friends,

The dictionary defines the word “milestone” as a significant event or a project in your life, a turning point. There have definitely been milestones in my personal life, including my term as President of the Obsessive Compulsive Foundation Board of Directors over the last four and a half years.

I have found myself using life’s milestones as a way to “chunk” periods in my life. There were

the years before I was married, my single years. There were the years before children, the time in which my husband and I finished our graduate degrees and started the process of nesting. From then on, the years were marked by special days, starting with the births of Alexis and Jared. We experienced the excitement of our children’s first milestones: the first tooth, the first step, the first birthday, the first day of school, the first year at camp, the first day of college.

Nothing prepared us for the toughest milestone, the day we heard the words, “your son has Obsessive Compulsive Disorder.” No matter how hard we tried to maintain a sense of normalcy for our daughter, it wasn’t possible for her either. As I look back on those years, I wonder how in the world we survived the impact and I know that the OCF was a big reason that we did.

These days Alexis is currently pursuing a Ph.D. in clinical psychology and Jared is working as a Research Coordinator in the OCD and Related Disorders Program at Massachusetts General Hospital. A few weeks ago, our family traveled to California to celebrate Alexis’ marriage. Jared, co-author of *The Thought That Counts*, toasted his sister and her new husband with a sensitive account of how much he appreciated the role Alexis had played in helping him cope with OCD. We are so proud of how they have handled this life-changing event.

As for my husband and I, we responded to Jared’s diagnosis by becoming involved with the OCF. We immediately felt the Foundation’s support for families and for individuals with OCD. Since I joined the OCF Board of Directors back in 2001 and became President of the Board four and a half years ago, the mission of the Foundation has remained the same, even as we have worked to reach a larger segment of the population.

A new milestone for the OCF occurred in January of this year. After a year of strategic planning with a consultant, the OCF headquarters moved from New Haven, Connecticut to Boston, Massachusetts. Members of the board helped with the move to Boston and the Foundation is now stronger than ever. Thanks to the dedication of many

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FROM THE FOUNDATION

(President's Message, continued)

capable individuals, the OCF programs continued throughout the transition process. Denise Egan Stack, an OCF Board Member, volunteered to organize and to run the OCF Annual Conference which was recently held in Boston. This was a huge undertaking and Diane Davey, Co-President, assisted Denise. Their strong marketing skills and their new format for professionals encouraged over 1100 consumers and treatment providers to attend this year's conference, thus breaking the record set for those attending an OCF Annual Conference.

As I step down from chairing the OCF Board of Directors, I look to the future with optimism, both for those with Obsessive Compulsive Disorder and for those who are working to make life easier for families who deal with OCD every day. When I visited the bookstore at the conference, I was pleasantly surprised with the number of books on OCD written by professionals and by those with OCD. This is definitely a change from the first time I attended a conference, fifteen years ago.

Although I will no longer be President of the Board, I will continue to participate as an OCF Board Director and I look forward to working with the other board members, the staff and volunteers. Looking ahead we need to support efforts to pass the Parity Bill now pending before Congress and to obtain funds for increasing the number of BTIs that train and improve the quality of Treatment Providers throughout the United States. Additional money must be earmarked for research that will one day find the genetic link for OCD. As a former educator, I also understand the importance of providing a format for educating teachers about OCD and will begin working with colleges to promote awareness and understanding of this disorder and how we can help those who live with it every day. The newly established Speakers Bureau, which consists of people with OCD, treatment providers and researchers, is another group within the OCF that will reach out to the public.

Diane Davey, the new President of the OCF Board of Directors, has shown that she is ready to lead the board and the Foundation for the next two years. I am sure that she will also find this new milestone in her life to be one of the most challenging and rewarding.

I feel fortunate to have been given the opportunity to make a difference in the lives of those who live with OCD. I want to thank my family, the members of the Foundation, the SAB, the Affiliates and the OCF Board of Directors for supporting me during these last four and a half years.

I wish you all well.

Joy Kant

President, OCF Board of Directors

OCF Bookstore Cleanout Sale!

The OCF currently has hundreds of books on OCD left over from its annual conference bookstore. Once we sell our remaining stock, we will no longer sell books through our national office. Please help us to clear out needed space, and order a book today!

Stock is limited. For more information, please visit <http://www.ocfoundation.org> for a list of available books, and to fill out an order form. Please allow 1-2 weeks for the processing and delivery of all orders.



OCF NEWSLETTER

The OCD Newsletter is published by the
Obsessive Compulsive Foundation, Inc.

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OCF Scientific Advisory Board
Michael Spigler, CHES,
and Rebecca Cyr, Editors

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 newsletter, the OCF's resources and activities include: an annual membership conference, website, training programs for mental health professionals, annual research awards, affiliates, and support groups throughout the United States and Canada. The OCF also sends out Info Packets and Referral Lists to people with OCD.

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 a licensed treatment provider.

THANK YOU!

On behalf of OCF and those we serve, thanks to the 1,100 people who made the 15th Annual Conference in Boston our most successful event ever! Patients, family members, treatment providers, and researchers from across the globe descended on Boston during the event held August 1-3.

For more than half of the attendees, it was their first conference and it left quite an impression. Here are just some of the many positive comments we received:

"This was (as usual) the best conference I attend all year!"

"So many great topics and experts in one place!"

"This conference gave me the push to keep fighting my OCD."

In addition to the more than 100 presentations, conference attendees were given the opportunity to participate in many other activities, including support groups, children's programs, and the 8th edition of Dr. Jonathan Grayson's popular "Virtual Camping" workshop.

Forty-four mental health professionals also attended our annual Advanced Behavior Therapy Institute (ABTI) held in conjunction with this year's conference. The ABTI was presented by Laura Summerfeldt, PhD, and covered the topic of "Not Just Right" OCD.

As usual, this conference would not have been a success without the hard work and commitment of volunteers too numerous to mention. However, two volunteers in particular, Denise Egan-Stack and Diane Davey, our Conference Co-Chairs and members of our Board of Directors, deserve special recognition for their relentless dedication to making this event a success. Thank you Denise and Diane!

We hope you'll join OCF and the rest of the OCD community at the 16th Annual Conference at the Hyatt Regency in Minneapolis, MN on August 7-9, 2009!

Best wishes,

Mike Spigler

Program Director
Obsessive Compulsive Foundation

A Special Bracelet to Benefit OCF: Follow-Up

Over 100 "Jane's Martha's Vineyard" bracelets, designed by Ruth Adomunes to honor her friend's son, Rick, a longtime sufferer of OCD, were sold at the OCF's 15th Annual Conference. All net proceeds from sales of these bracelets went to benefit OCF and its programs.

To order these bracelets please call the OCF national office at (617) 973-5801.



Join Us!

OCF 16th Annual Conference
Minneapolis, MN
August 7 - 9, 2009



FROM THE FOUNDATION

Behavior Therapy Institute in Berkeley, CA Trains 40 Professionals

Some of the most well-known names in the treatment of OCD met at the Alta Bates Summit Medical Center in Berkeley, CA for the first of two Behavior Therapy Institutes (BTI) being offered by OCF in 2008. Psychologists, social workers, licensed counselors, and marriage and family therapists from nine states took part in the intensive, three-day training program on OCD and its treatment.

The BTI, developed by C. Alec Pollard, Ph.D., seeks to help address the shortage of therapists properly trained in the cognitive behavioral treatment of OCD.

A second BTI will be held in Chapel Hill, NC, October 17-19, 2008. If you are a mental health professional licensed to practice independently in your state, see the announcement below for more information on how to register.

Mark Your Calendars!
October 17, 18, & 19 in Chapel Hill, NC
The 2nd 2008 OCF-sponsored Behavior
Therapy Institute



An In-Depth 3-Day Training Program
 in
State-of-the-Art Cognitive Behavior Therapy for OCD

- Experienced OCD Faculty
- CE Credits Available
- Low Registration Fee

Hurry! Space is very limited!

For More Information Regarding the Institute:

Check the OC Foundation website (www.ocfoundation.org) or Michael Spigler at (617) 973-5801, mospigler@ocfoundation.org

This program is co-sponsored by IPPA, Inc. and the Obsessive Compulsive Foundation. IPPA, Inc. is approved by the American Psychological Association to sponsor continuing education for psychologists. IPPA, Inc. maintains responsibility for this program and its content. IPPA, Inc. is approved by the Department of Professional Regulation in Florida as a Continuing Education Provider for Licensed Clinical Social Workers, Marriage and Family Therapists, and Mental Health Counselors. Contact hours include up to 22.5 credit hours. Provider # BAP 260, Exp. 3/31/09. Application has been made to the National Board for Certified Counselors (SP-1515). Application has been made to the National Association of Social Workers (Provider #886371887).



A Defining Moment: OCF Launches Speakers Bureau

By Jeff Bell

“My friend Bill is so OCD about keeping his room clean!”

Chances are pretty good you’ve overheard a comment similar to this one in recent months. And if you’re like me, you probably cringed.

I’m not sure exactly when OCD became an adjective and, worse yet, one so terribly misused as a synonym for “anal-retentive”; but, in far too many circles, I’m afraid it has.

I mention this not to complain about those who would diminish the severity and complexity of OCD – it’s not their fault – but rather to point to the challenge that we in the OCD community face in raising awareness about the disorder.

There is, however, an opportunity in this challenge. A big one, really. As the term “OCD” finds its place in the American lexicon, we collectively have a chance to help shape its definition and the discussion surrounding it. What we need, I believe, is a consistent, accurate message regarding OCD and its treatment and a means for proactively disseminating this message.

It was with this goal in mind that I approached the OCF Board some months ago with the idea of creating a speakers bureau. Never could I have imagined how responsive the Board would be, nor how swiftly and diligently the OCF staff would work to make this concept a reality.

Now – as you may be aware if you’ve visited the OCF web site recently – the OCF Speakers Bureau is officially up and running and I couldn’t be more excited about its prospects. With our small but highly qualified group of OCD treatment experts, researchers, and consumers, we stand ready to help raise awareness and debunk misconceptions about OCD, while offering hope to the millions of Americans battling it.

The inquiries are already coming in, and with your help, I know we can put our speakers to work across the country. If you haven’t done so already, please take a few minutes to peruse our online Speakers Bureau overview (at <http://www.ocfoundation.org>), ask yourself if there are organizations in your community – mental health groups, universities, etc. – that might be interested in booking one of our speakers, and consider pointing these organizations our way. While the OCF is actively marketing the bureau nationally, this project, at its core, is a grassroots one.

On behalf of all of us in the OCF Speakers Bureau, thank you in advance for your time and support. Together, I know we can make this a defining moment in OCD outreach.

Jeff Bell is a National Spokesperson for the OC Foundation. He is the author of “Rewind, Replay, Repeat: A Memoir of Obsessive Compulsive Disorder” and co-anchors the afternoon news at KCBS Radio in San Francisco.

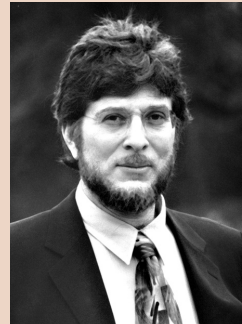
Our Speakers Bureau Members:*



Jeff Bell



Scott Granet, LCSW



Jonathan B. Grayson, PhD



Jared Kant



Elizabeth McIngvale



Fugen Neziroglu, Ph.D.,
ABBP, ABPP



C. Alec Pollard, PhD



Sabine Wilhelm, PhD



Robin Zasio, PsyD, LCSW

* Sanjaya Saxena, MD
(no picture provided)

AFFILIATE UPDATE

New OCD Chicago Website Answers Your Questions

OCD Chicago has launched a brand new web site for individuals with OCD, family members and friends! Go to www.ocdchicago.org and find exciting new features to help you get the information and support you need.

Click on the section that fits your interest: Individuals, Parents, Friends & Family, College Students, OCD Facts or Personal Stories of OCD treatment successes. Special information is also available for members of the clergy and media. You'll find the web site is friendly with easy navigation. And you can print all of the content, email items to a friend or post to your social network.

More new features include an Expert Perspectives section with articles from recognized experts in the field of OCD, and an "Ask the Experts" blog that allows visitors to post comments and questions and review responses on the web site.

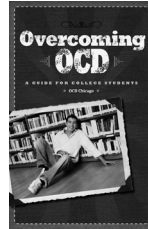
Within the next two months, a special School Personnel section – the OCD Education Station -- will be added to assist teachers, social workers and counselors in making a difference in the life of a child struggling with OCD.

Visit www.ocdchicago.org today!

New OCD Guide for College Students

OCD Chicago announces our newest OCD guide: *Overcoming OCD – A Guide for College Students*, published through

a grant from the Obsessive Compulsive Foundation.



Comprehensive and supportive, this guide reviews the special characteristics of managing OCD on a college campus. It offers encouraging and practical steps that college students with OCD can take to improve their lives.

Overcoming OCD addresses:

- Coping with the special stressors of being away from home and family
- Being away from a trusted therapist
- Life in a dorm
- New roommates and relationships
- Contamination issues
- The pressure of classes and school work
- How to handle OCD triggers
- Disability accommodations

The new guide will help college students understand what to expect and recommend strategies to access local treatment, support and other resources. It will help college students with OCD become powerful agents of change for their own recovery.

Overcoming OCD – A Guide for College Students is available as a free downloadable PDF at www.ocdchicago.org, the OCD Chicago web site. Individuals who are unable to download or who do not have a computer can write for a free copy by sending their name, full mailing address and the word "College" to OCD Chicago,

2300 Lincoln Park West, Chicago, IL 60614 or by email to info@ocdchicago.org.

Western PA Affiliate Hosts Trail Race



The OC Foundation of Western Pennsylvania will host its 2nd Annual Dirt Monster 5 Mile Benefit Trail Race and 1 Mile Trail Walk on Saturday, November 1 at 9:30AM in North Park and will include individual and team cross country style competitions with awards given in Open, Masters and Team divisions. Early registration fee \$15, Race day registration \$20, additional \$5 registration fee for teams. For more information and online registration please visit www.ocfwpa.org or email ocdirections@verizon.net for mail-in registration forms.

OCF of Greater Boston's Les Grodberg Memorial Lecture Series

The OCF of Greater Boston, in conjunction with McLean Hospital, presents a series of preeminent speakers in the field of OCD and related disorders. Each presentation takes place from 7:00 – 8:00pm and is held at McLean Hospital's De Marneffe Cafeteria Building, Room 132, Belmont, MA 02478.

October 7, 2008	The Basics of ERP for OCD	Marilyn Zegman, PhD Behavior Psychotherapy Center
November 4, 2008	Perchance to Dream	James Claiborne, PhD South Portland, ME
December 2, 2008	Obsessed and Distracted: Having OCD and ADHD	Roberto Olivardia, PhD McLean Hospital/Harvard Medical School
January 6, 2009	Treating Perfectionism	Jeff Szymanski, PhD OC Foundation

NOTE: Please check the website: www.ocfboston.org for information on changes to the schedule or cancellations.

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 and 132. 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.

First Annual OCD Bike Ride

By Rob Fox

A small gathering of seven bike riders came together for the 1st Annual Boston OCD Bike Ride, which was held in Concord, Massachusetts on September 7, 2008. Hurricane Hannah sailed out of Boston just in time for our riders to head out on the 27 mile scenic route that traveled by farms and ponds.

I am honored to have had the opportunity to organize this ride for the OCF. I have always had a love for riding bicycles, having led bicycle trips since I was 18 years old. It had been a plan of mine to lead a ride for the OCF for several years, but I hadn't been ready to make it public that I have OCD. Now I am at a point in my life where I feel there is absolutely nothing to be ashamed of, and I can proudly raise funds for this important cause. As I rode each mile, I felt stronger knowing that I was carrying an important message of hope for those with OCD who weren't feeling well enough to ride. I wanted to give back for all the help that I have received from the dedicated professionals that I have worked with along my journey to recovery.



*Mike Spigler, OCF Program Director;
Rob Fox, bike ride Organizer; Joy
Kant, OCF Co-President*



Next year, I'm planning to organize another ride in early September, so stay tuned and watch the OCD Newsletter for details. It's never too early to start collecting donations and to begin plans for an even bigger and better ride next year.

Ride safe and warm regards!

RESEARCH DIGEST

Selected and abstracted by Bette Hartley, M.L.S. and John Greist, M.D.

Madison Institute of Medicine, Inc.

This Research Digest focuses on the burdens of OCD on sufferers, their families, employers and the health care system. It's a bitter-sweet moment as Bette Hartley ends her tenure as lead author of the Research Digest. From its inception, Bette has selected the articles, written their reviews and graciously accepted my occasional emendations and overviews. We all owe Bette a debt of gratitude for this labor of love which she gives up now for an even greater love – time with her daughter and grandchild. We thank you and wish you well. John Greist.

Medical utilization across the anxiety disorders

Journal of Anxiety Disorders, 22:344-350, 2008, B. Deacon, J. Lickel and J.S. Abramowitz

Electronic medical records of 171 individuals referred to an anxiety disorders clinic were reviewed. Frequency of office visits and medical services in the year before evaluation was compared for patients with panic disorder (N=41), generalized anxiety disorder (N=36), specific phobic disorder (N=32), OCD (N=31) and social anxiety disorder (N=31). The average anxiety patient had over 6 outpatient visits during the 12 months before evaluation at the anxiety disorders clinic. Regarding medical specialties, anxiety patients most often utilized dermatology (27.5%). Panic disorder patients used the most medical services overall, but other anxiety disorder patients also were high utilizers of medical services. There was little difference in medical utilization between the other anxiety disorders. Before receiving effective treatment, individuals with anxiety disorders were frequently

using medical services. Researchers concluded that the financial burden created by this high use of medical services could be decreased with improved recognition and treatment of anxiety disorders.

Comparison of healthcare use and costs of adult patients with “pure obsessive-compulsive disorder” versus “pure depression”: nine-year (1997-2006), large-scale, retrospective claims analysis of Florida Medicaid enrollees

Journal of General Internal Medicine, 23 (March Suppl):269-270, 2008, C. Hankin, L.M. Koran, L. Culpepper et al.

Florida Medicaid insurance claims were examined, looking at the cost to treat OCD versus depression. Only patients with “pure” OCD or depression were included, meaning patients with comorbid disorders (such as bipolar disorder or psychosis) were not included in the analysis. The per patient number of healthcare claims was approximately 2 times greater for patients with OCD than for patients with depression. Patients with OCD used significantly more outpatient medical services and incurred 2 times greater outpatient medical costs than patients with depression.

The descriptive epidemiology of commonly occurring mental disorders in the United States

Annual Review of Public Health, 29:115-129, 2008, R.C. Kessler and P.S. Wang

Statistics were reviewed on the prevalence of commonly occurring mental disorders in the United States. The most recent statistics came from the National Comorbidity Survey Replication (NCS-R), a survey of

9,282 adults in the United States who were interviewed face to face in their homes between February 2001 and April 2003. Mental disorders were highly prevalent—about half the population having one or more such disorders in their lifetimes and about one fourth of the population had a disorder in the year interviewed. Most individuals with a history of mental disorder had first onsets in childhood or adolescence. Only 32.9% of individuals received treatment, thus most individuals with mental disorders remain untreated. OCD was assessed in a random one third of the sample (N=1,808) and there was a lifetime prevalence of 1.6% and a current prevalence of 1%. Additionally, the anxiety disorder with the highest proportion of serious cases was OCD. As most seriously impairing adult mental disorders were associated with child-adolescent onsets, reviewers suggested greater efforts are needed to study the public health implications of early detection and treatment of initially mild and currently largely untreated child-adolescent disorders.

Family burden of compulsive hoarding: Results of an internet survey

Behaviour Research and Therapy, 46:334-344, 2008, D.F. Tolin, R.O. Frost, G. Steketee et al.

Compulsive hoarding, common in OCD, refers to compulsive collecting of and inability to discard items that others consider of little use or value. This study examined the burden of hoarding on family members. An email invitation to participate in the study was sent to over 8,000 individuals who had contacted the researchers after several national media appearances for information on hoarding. Of the respondents, 665 adults who reported having

a family member or friend with hoarding behaviors completed an internet-based survey. The study found that compulsive hoarding adversely impacted not only the hoarding individual, but also those living with them. During childhood, living with an older individual who hoards, in a severely cluttered home, was associated with elevated reports of childhood distress and family strain, including less happiness, more difficulty making friends, less social contact in the home, and embarrassment about the condition of the home. Family members reported high levels of patient rejection attitudes, suggesting high levels of family frustration and hostility. Negative family attitudes have been associated with poor treatment response in OCD. Researchers suggested it may be useful to work with families, provide education on the harmful effects of negative attitudes, reframe the patient's behavior as coming from the illness rather than malicious behavior, and improve coping strategies for family members.

Family burden, quality of life and disability in obsessive compulsive disorder: an Indian perspective

Journal of Postgraduate Medicine, 54:91-97, 2008, G.P. Gururaj, S. Bada Math, J.Y.C. Reddy et al.

This study assessed family burden, quality of life and disability in 35 patients with OCD and then compared them to 35 patients with schizophrenia of comparable severity. Severe OCD was associated with significant disability, poor quality of life and high family burden, often comparable to schizophrenia. OCD patients reported similar reduced quality of life in areas of social functioning, although patients with

OCD reported better physical and environmental quality of life than those with schizophrenia. The OCD patients had major impairment in several areas of functioning, such as work, social and family relationships. Families of OCD patients reported similar family burden as families of schizophrenia patients with disruption of family leisure, family interactions and effect on physical and mental health of family members. This study is from the National Institute of Mental Health and Neuro Sciences in Bangalore, India and reflects a world-wide concern with the need to improve the diagnosis and treatment of OCD.

Demographic and clinical characteristics associated with treatment status in family members with obsessive-compulsive disorder

Depression and Anxiety, 25:218-224, 2008, B. Cullen, J.F. Samuels, A. Pinto et al.

This study investigated factors influencing treatment status in 602 family members with OCD. Families included in the study needed to have at least two OCD-affected siblings and then additional first- and second-degree relatives were considered for inclusion. A comparison was made between individuals who had received treatment (N=468) and those who had not (N=134). Rapid onset of OCD symptoms, severe OCD, multiple obsessions and compulsions, and comorbid depression were all positively associated with receiving treatment. Older age and comorbid obsessive-compulsive personality disorder (OCPD) were negatively associated with receiving treatment. Sex and age of onset were not related to receiving treatment. Most interesting

was the average length of time from onset of OCD symptoms to receiving treatment was 13.8 years, a long time. There was a direct relationship between current age and time to treatment, with younger individuals receiving treatment sooner. As subjects in this study were family members, the finding that younger individuals with OCD had a shorter delay in receiving treatment may reflect a higher awareness of OCD and its treatment in these families.

Reasons for inadequate utilization of cognitive-behavioral therapy for obsessive-compulsive disorder

Journal of Clinical Psychiatry, 69:676, 2008, L. Baer and W.E. Minichiello

Cognitive-behavioral therapy (CBT) has proven effectiveness in the treatment of OCD and is a recommended first-line treatment. As the majority of individuals with OCD never receive CBT, these researchers tried to determine why. Internet survey responses from 222 individuals with OCD were evaluated. While 84% of respondents reported having sought drug treatment, only 53% reported having sought CBT treatment, and only 31% reported having been treated by a CBT specialist. The most frequent reasons for not seeking CBT were "I didn't think it would help" and "I wasn't aware of this treatment." Surprisingly, cost and unavailability of CBT experts were less common reasons for not seeking CBT. Researchers suggested "we need to modify the common attitude among sufferers that nondrug treatment is inferior to drug treatment."

INTENSIVE TREATMENT PROGRAM INTERVIEW

University of South Florida Opens New Child and Adult Obsessive-Compulsive Disorder Treatment Program: An Interview with Eric Storch, Ph.D.



Dr. Storch is the Director of the USF Child and Adult OCD Treatment Program, which is sponsored by the Department of Pediatrics. This

program is located in the Rothman Center for Neuropsychiatry, 800 6th Street, South; St. Petersburg, FL 33701. Tanya Murphy, MD, serves as the Director of the Rothman Center.

NEWSLETTER: When did you open your Child and Adult OCD Treatment Program?

DR. STORCH: Our program is quite new, having been opened in July of this year. We identified a significant need in the state of Florida for specialized OCD care, and were fortunate to have the opportunity to move to the University of South Florida to develop this program.

NEWSLETTER: Are there age limits for children to be in the Program? What are they?

DR. STORCH: We see children as young as 3-years-old and adults across the lifespan. Given Dr. Murphy's research expertise in Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS), we often have very young children participate in our clinical and research programs.

NEWSLETTER: Will the OCD Treatment Program be devoted completely to the treatment

of OCD, or will other anxiety disorders affecting children be treated there?

DR. STORCH: Although we specialize in the treatment of OCD and related disorders (such as trichotillomania, body dysmorphic disorder, or Tourette's Disorder), we are open to and able to serve all children and adults with anxiety disorders. The intensive outpatient program, however, is specific to individuals with OCD, as the intervention is particularly tailored to treating this disorder.

NEWSLETTER: What are the treatments of choice for OCD that are used in your Program?

DR. STORCH: We believe in an integrated and evidence-based approach in the treatment of children and adults with OCD that includes cognitive behavior therapy (CBT) and medication management. I direct the CBT portion of the program, while Dr. Murphy heads up the pharmacological side to treatment.

NEWSLETTER: Why do you consider CBT as the first line treatment of OCD?

DR. STORCH: We believe that the available scientific evidence strongly supports CBT as the first-line treatment for OCD in both adults and children. For example, the Pediatric OCD Treatment Study that was published in the *Journal of the American Medical Association* concluded that CBT alone or

with concurrent medication is the first-line treatment of choice for children and teens with OCD. Among adults, these results have been consistent indicating that CBT was superior to medication treatment alone. Thus, CBT alone or with medication should be considered the first-line approach. We strongly believe in an integrated approach to treatment, stressing a combination of both treatment modalities when appropriate, in order to meet the needs of each individual. In short, our philosophy is to use the interventions that work to maximize each person's quality of life.

NEWSLETTER: When would you use medication as part of the treatment of a child in your program? What kind of medications do you use?

DR. STORCH: Medical management is based on the unique qualities of the person and his/her family. Obviously, not every person requires medication. In general, we believe that medications specific for OCD are useful for moderate to severe OCD, when anxiety or depression are too severe to allow for a trial of CBT, or when CBT alone has not resulted in sufficient improvement in symptoms. Treatment of comorbid conditions with appropriate medications, such as stimulants for ADHD, may also improve CBT outcomes. Medications for OCD would include serotonin reuptake inhibitors. The FDA-approved medications for pediatric OCD

would be considered first line. Augmentation strategies with other classes of medications are considered after CBT and two trials of SSRIs have not been successful.

NEWSLETTER: Is a treatment plan done for each person when they first come to the Program? Who is involved in creating the person's treatment plan?

DR. STORCH: Based on a comprehensive assessment, an individualized treatment plan is made for each child or adult when they come to the program. Each person's treatment plan is developed by myself and Dr. Murphy, in conjunction with the person and his/her significant others. We believe in a multidisciplinary approach and thus, meet frequently as a team to discuss cases.

NEWSLETTER: Are parents and the children themselves involved in setting the treatment plan when children come for therapy?

DR. STORCH: Parents and children (and other family members if appropriate) are included extensively in determining the treatment plan and throughout the treatment process. With parents, our approach is based on a "Parent as Therapist" model. In other words, we believe that if parents know the theory, nature, and treatment of OCD, then they will be effective figures in maintaining gains and preventing relapse. This education starts in the initial evaluation with the child and his/her family where we provide extensive education about OCD and CBT.

NEWSLETTER: Is your program a residential program or an outpatient program?

DR. STORCH: We offer both an intensive outpatient treatment program, as well as more standard weekly cognitive-behavioral treatment. Currently, we do not offer a residential program.

NEWSLETTER: Does an enrollee in your OCD Program attend sessions every day with a behavior therapist? How long is each session?

DR. STORCH: For the intensive program, sessions are held every weekday and last 90 minutes. For the weekly program, sessions are held once to twice per week and last approximately 90 minutes as well. Additionally, people are given an average of 60-90 minutes of homework to complete outside of their scheduled therapy sessions.

NEWSLETTER: Is there a set time period for a patient's treatment in this program? How many weeks is it?

DR. STORCH: The average duration of treatment in the intensive program is 3 weeks. That said, sometimes people need more or less treatment depending on the symptom severity or their comfort in dealing with symptoms independently. We are always able to accommodate accordingly. Sometimes we schedule additional intensive sessions and other times patients finish the program early.

With regards to the weekly program, people participate in an average of 12-14 sessions. Again, some people finish treatment earlier while others need more time; again, we are able to accommodate the person's needs and revise the treatment plan accordingly.

NEWSLETTER: Does your program service only children and adults who live within driving

distance of the clinic, or are there options for patients that come from farther away?

DR. STORCH: Both the adult and child programs serve people from all over the world. We have had families come from Europe, Asia, and South America to receive treatment, as well as many from most of the states in the US. Although we do not offer an inpatient program, we help families traveling from long distances secure hotel reservations at nearby extended stay facilities. There is also the option of a Ronald McDonald House that is next to our building for inexpensive housing.

NEWSLETTER: It's been determined that a child's classroom teacher can be an effective behavior therapy coach. Will the treatment providers in your group consider dealing with a teacher who is interested in helping the child with his/her CBT?

DR. STORCH: With parent and child consent we allow any caregiver of the child (e.g., teachers, relatives, a nanny) to participate in the child's treatment. When teachers have asked to be involved in the past, at minimum we have consulted with the teacher by phone and provided written educational material about CBT for OCD. We also communicate the child's behavioral goals and coping strategies to the teacher as the child's therapy progresses. When a teacher is able to attend a session with the child and the child's family, we welcome the opportunity to have the teacher observe the therapy and ask questions about implementing CBT in the classroom.

(continued on p. 12)

(Storch Interview, continued)

NEWSLETTER: Will the patient, whether a child or adult, be trained how to recognize a relapse and be taught how to deal with it?

DR. STORCH: We believe this is an important part of the treatment process. From the onset of treatment, we teach people to identify obsessive thoughts and compulsive behaviors. We also discuss the relationship between compulsive behaviors and maintenance of OCD symptoms. After they understand these basic concepts we ask them to guide their own therapy and make decisions about the things they should be working on outside of the therapy sessions. Prior to completing treatment, we pose future challenges to our patients and ask them to identify three things: 1) how to address an obsession through cognitive 'talking back,' 2) what to do if they realize they have been engaging in compulsive behavior, and 3) how to know if s/he needs a therapy "booster session." We want each patient to be able to: 1) try to use cognitive strategies to address the anxiety and refrain from engaging in the compulsive behavior, 2) stop the compulsive behaviors in the future and perhaps set up some exposure exercises, and 3) return to treatment when steps one and two are not working, and preferably before things get so bad that the patient feels overwhelmed or out of control.

NEWSLETTER: What kind of follow-up will be done for people who come through the program? Will the members of your treatment team be willing to consult with their regular treatment provider?

DR. STORCH: We strongly advise patients to continue with follow-up care after completing an intensive treatment course. Patients who live in the area can continue treatment at our clinic on a more intermittent basis (e.g., weekly). Those who live greater distances away are either followed through phone contact or are referred to cognitive-behavioral practitioners in their area. If this isn't possible, we are happy to provide phone supervision for the clinician as needed or phone sessions with the patient. Given the small number of clinicians with expertise in CBT for OCD, providing phone sessions is a common occurrence.

NEWSLETTER: Are the services and treatment that your group provides covered by private insurance, Medicare or Medicaid?

DR. STORCH: Our services are covered by many private insurances. Medicare covers our services within the constraints of Medicare regulations in a teaching hospital. Unfortunately, Medicaid does not cover services by psychologists in Florida. We do offer a substantial discount for people paying out of pocket and also have a number of research studies that people can participate in.

NEWSLETTER: Are there any scholarships or programs that will help families who cannot afford the treatment at your Program?

DR. STORCH: There are a number of ways we can make treatment more affordable for people in need. Regarding housing, families can stay at the Ronald McDonald House, which is within walking distance to our facility. Participating in research is another way that we can cut the

costs for families. For example, we have several treatment studies that offer free CBT, while other studies provide assessments and evaluations at no cost for participating people. Finally, we are able to offer a 40% discount to those people who do not have insurance to cover treatment costs.

NEWSLETTER: Who is the contact person for this Program?

DR. STORCH: People can contact me directly at (727) 767-8230 or by email at estorch@health.usf.edu.

The Obsessive Compulsive Foundation 2009 Research Awards Request for Proposals

Submission Period:

December 1, 2008 – February 13, 2009 at 12pm

The Obsessive Compulsive Foundation is committed to finding and promoting effective treatment for everyone. 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; and all aspects of OCD and the OC Spectrum Disorders that will lead to prevention and treatment advances.

The Foundation has been awarding research grants since 1994. Since then, it has funded over \$2,500,000 in OCD research.

For application guidelines and submission information, go to <http://grants.ocfoundation.org>.

Don't Try Harder, Try Different

by Patrick McGrath, Ph.D.



One of the most rewarding parts of my job is that I get to help make positive changes in people's lives. I love to hear from my patients years after treatment when they write or call and tell me that they are graduating from college, are getting married, or are having a child. It is also at these times though that OCD can try to rear its ugly head again, so I try to remind people of a few basic techniques to keep in mind as they take on new challenges. I have summarized these ideas in a talk I give at the Anxiety and OCD clinic that I run at Alexian Brothers Behavioral Health Hospital in Hoffman Estates, IL. The title of this talk is called: "Don't Try Harder, Try Different". I gave this same talk at the OCF Annual Conference this year in Boston, and the OCF has asked me to recap it for this edition of the newsletter.

So, the first thing to do is eliminate the word "SHOULD" from your vocabulary. If you think about it, you have never used the word SHOULD to describe something that went well. It is always negative. Whenever a patient in the clinic says SHOULD, we have them stop right away and change what they say to "I wish," or "I want," or "My goal is." There is no SHOULD involved, because if it SHOULD be a certain way it would be that way – SHOULD is an opinion, and if you go around thinking that your opinion is the only one that counts, you will have up to 6.5 billion people disagreeing with you. Plus, SHOULD just leads to arguments, because if you tell me that I SHOULD do something that is a part of your ritual, and I choose not to, then you will be mad at me because I would not give in to your OCD as you have. It is not fair to make others do what you want them to just because it makes you comfortable for a few minutes. In fact, every time they do give in to you, they might as well tell you that they want your OCD to get worse, because that is what happens each time you do a ritual.

Second, "CAN'T" is not a word that we accept at the clinic. If you tell us that you CAN'T do something, then we are not going to help you with that situation. CAN'T implies that you have no ability to do a certain thing, and if you lack the ability to do something, then we lack the ability to help you – you either will or you won't do something. So, we work with people to develop hierarchies of their fears and work up to

their worst fears in a gradual format. But, we never believe that someone CAN'T do something that they are afraid of – it is a choice, and it is always a choice. Someone came up to me at the conference to challenge me on this after my talk, and I said to them "Imagine your husband were to get cancer, and I told you that I had the cure, and I would give it to you if you were to stop doing your rituals – would you do that?" She said that she would in a heartbeat, and I told her that if she could just choose to stop doing her rituals for that, she could do it for herself and her own health as well.

(continued on p. 14)

(Don't Try Harder, continued)



Third, “PRACTICE MAKES ROUTINE.” There is no such thing as perfect, even though OCD will tell you that there is. As most of you know by now, OCD does nothing but lie or tell half truths all of the time. Therefore, practice can never make perfect, because it does not exist, even if your OCD tells you differently. But, practice does make routine, and your routines are your rituals that you just do over and over, strengthening their hold on you every time.

Fourth, “CONTROL IS AN ILLUSION.” OCD tells you that you can have total control over things if you just do what it says. So, let’s test if total control is possible. First, stop blinking for the next 5 days. If you really are able to have total control over things, this ought to be no problem for you. Second, do not think about a Pink Elephant. Just have no thoughts of them whatsoever. Forget I even mentioned a Pink Elephant at all. Do you see how difficult this is? So, when OCD says that if you just do what it tells you and then you will be in control of everything in your life, it is just another lie.

Fifth, “YOU ARE NOT SPECIAL.” You are unique, but the rules of the world apply to you in the same manner as they apply to everyone else. Yet, your OCD will tell you that you need to do things that even you would say were ridiculous for other people to do – so you must think that you are special. Yet, if living life without rituals works for others, it can work for you as well. What seems to come into play here are the concepts of Possibility and Probability. Many people with

OCD have the idea that because something is possible, it is also very probable – especially for them, and that is where specialness comes in to play. They would not say that the horrible things their OCD tells them are possible for themselves are also just as possible for others (such as, “If you think about someone dying it is fine, but if I think about it, then I have to say several prayers or else they really will die), and therefore it is as if the universe has selected them to be someone that will be the target of doom and gloom more so than anyone else. Again, just another lie from your OCD.

Lastly, I contend that all things that people are anxious about are actually NEUTRAL, and are purely subject to their PERCEPTION. Anxiety is not a fear of a thing as much as it is a fear of the way we think about that thing. I personally enjoy bungee jumping, while others tell me that there is no way they would ever do it because it just looks scary. So, it is scary? Well, not to me. Or, is it fun? Not to them. So, what we have here are different PERCEPTIONS of the same event. Now transfer this to your OCD and recognize that your PERCEPTION of what you are anxious about is not shared by most people, therefore the person who is probably incorrect in their assessment of the situation is you and not everyone else who does not do your ritual.

So, let’s review everything that I have said: People with OCD PERCEIVE NEUTRAL experiences in a SPECIAL way, thinking that they have to CONTROL them to make them PERFECT, otherwise they CAN’T handle it, and that is just the way that their life SHOULD be. And, if this is the way that you approach life, there will be a lot of anxiety.

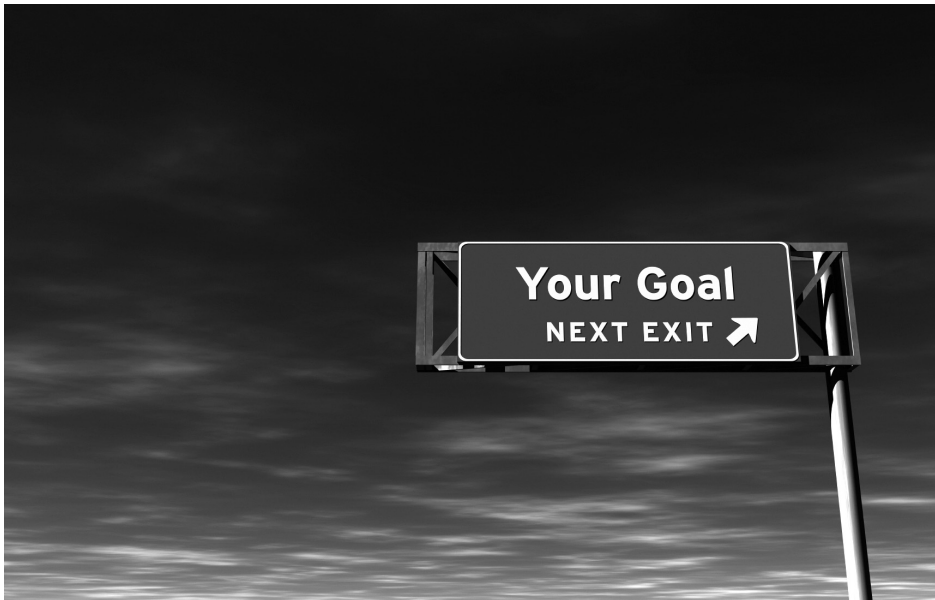
I hope that this overview has been helpful for all of you. Keep on challenging OCD – it is a battle that can be won, and all my best to you as you take the journey to recovery.

Dr. Patrick B. McGrath is a licensed psychologist who specializes in the treatment of OCD. He is the Program Director of the Anxiety and OCD Clinic at Alexian Brothers Behavioral Health Hospital in Hoffman Estates, IL. Dr. McGrath is the author of the self-published workbook “Don’t Try Harder, Try Different” and “The OCD Answer Book” (published by Sourcebooks). Dr. McGrath can be reached at: patrick.mcgrath@abbhh.net. Additionally, you can contact the Intensive Therapy Program at Alexian Brothers at 847-755-8566.

Fighting Anxiety Using “Your Greater Good”

Dr. Robin Zasio, Psy.D., LCSW

Director of The Anxiety Treatment Center and The Cognitive Behavior Therapy Center of Sacramento



Those of us who specialize in treating anxiety disorders are intimately familiar with how difficult it can be for our clients to do the hard work, which often entails Exposure and Response Prevention Therapy (ERP). After days, months, and even years of engaging in compulsions and avoiding triggers that will set off anxiety, they are now encouraged to face them down. It's impossible for me to count the number of times I've heard the question: "Why would I want to do that? Don't you know what I've gone through to avoid my fears?"

After treating hundreds of clients, I have seen the lengths individuals have gone to in order to evade the experience of fear and anxiety. Conversely, I have also seen the devastating consequences of avoidance and compulsions. With the proper application of ERP, however, lives can be reclaimed. It's an amazing paradox of learning that by systematically confronting your fears, a desensitization process will occur, and your anxiety associated with those triggers will slowly fade.

This process is easier said than done. For the therapist, it requires finding ways to gently encourage our clients to do the hard work. For the client, it's finding the strength to do the hard work. This is where the concept of motivation comes into play. If we can help our clients to find motivational factors to do the difficult tasks and exercises involved in ERP, we can help them to see at the outset that there will be a "greater good" that will result.

"Your Greater Good" is a concept developed by Jeff Bell, author of *Rewind, Replay, Repeat: A Memoir of Obsessive Compulsive Disorder*. YourGreaterGood.com is a joint outreach project of Jeff and The Anxiety Treatment Center, aiming to add a new element into ERP in the treatment of Obsessive Compulsive Disorder (OCD) and other anxiety-related conditions. The project is an outgrowth of my clinical experience working with those struggling with anxiety and Jeff's firsthand experience confronting his own OCD treatment challenges. Both Jeff and I are strong advocates of behavior therapy, and we know that these evidence-based techniques can prove especially challenging. Introducing a new "Greater Good" perspective will not only foster enormous success in treatment, it can also help our clients to reclaim their lives.

The Greater Good Perspective Shift (GGPS) is a simple but powerful concept allowing people with OCD and other anxiety conditions to reframe their decision-making, even in the throes of heightened anxiety. In reference to OCD, the following basic assumptions are at its core:

Because OCD causes an individual to think in black and white terms, the "default" choices he/she weighs tend to be "right" vs. "wrong" or "good" vs. "bad." As seen through the distorted lenses of OCD, "good" choices are those that reduce fear and alleviate doubt; "bad" choices are those that increase fear and introduce doubt. Because compulsions temporarily reduce fear and/or doubt, they are almost always seen as "good" choices.

A "Greater Good" framework acknowledges the perceived (though distorted) "good" of acting on compulsions, but also introduces a "greater good" choice—one that is larger than OCD and, in some way,

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(Fighting Anxiety, continued)

enhances one's own sense of purpose or is of service to others. Because "purpose and service" tend to trump "fear and doubt" as human motivators (our contention), this framework shift serves to lead individuals with OCD to far more productive decisions... including those essential to tackling traditional ERP therapy.

Let's try out some examples. If you've read Jeff's book, you may recall that one of his triggers involved driving. After going over a bump or pothole in the road, his fear was that he had hit and harmed someone. On several occasions he cites that he would "rewind and replay" the stretch of the road, and "repeat" the compulsion of returning to check it. After multiple checks, doubt would still trump his visual recognition that there was nothing there, and he'd find himself checking again... just in case. In the advanced stages of Jeff's therapy, he was able to recognize that, while in the moment, his OCD would tell him that the "good" choice would be to go back and check, and the "bad" choice would be to sit with what might feel like unbearable anxiety and fear, the Greater Good choice would be to resist the compulsion so he could: (1) get to work on time (and be of service to his employer); (2) avoid the risk of getting fired and losing his paycheck (and continue being of service to his family); and (3) feel good about himself because he did not give in to his fear, knowing that his continued recovery will allow him to pursue his life goals (and enhance his sense of purpose). In this fashion, he was able to find motivation to do the difficult work that, years prior, seemed impossible.

In another example, imagine someone who is diagnosed with Social Anxiety Disorder. For some with this condition, just going to the store can produce tremendous anxiety, imagining the people they may come in contact with; the fear of what others might think of them; and the potential for uncomfortable interactions. In this case, instinctively the "good" decision might be to stay home where it is "safe," and the "bad" decision would be to go and risk the above noted situations. The Greater Good choice would be to do their exposure exercises and risk that what they fear might happen, and sit with the uncomfortable feelings, for perhaps some of the following reasons: They will be able to get groceries; leave their home where they may have remained captive; and have a positive interaction with other people.

So the idea here is not to replace or take away from any of the ERP principles; rather it is to help find ways to do the arduous work of facing one's fears by adding a motivational perspective to help get through the process. We recognize that we have not reinvented the wheel, so to speak, as much of this is quite obvious. Most of us live our lives through greater good principles. As therapists, we may set our alarms to get to work on time so we can help others, but we don't necessarily think about it in those terms. We make dinner for our family so that their bodies are nourished, but don't think about that as a greater good. And it's not necessary that we do so, as these are hidden motivators that drive our behavior. But for those battling OCD and other anxiety conditions where ERP is involved, calling up those Greater Good motivators that otherwise may have remained hidden can help them persevere through some very challenging tasks.

As a provider dedicated to helping others struggling with fear and doubt, I can personally attest to how these principles have made a difference. It is my hope that the YourGreaterGood.com project will not only provide other therapists with additional tools to help their clients face their anxiety, but also to play a role in enhancing the concept of treatment motivation.



FROM THE FRONT LINES

My Life with Schizoaffective Disorder and Obsessive-Compulsive Disorder

by Steven Pavisich

I am a 39 year old sufferer of both Schizoaffective Disorder and Obsessive-Compulsive Disorder. I might say that I have run a course of ups and downs over the last 20 years, ever since I was diagnosed with both disorders. While I can say that I have improved substantially, I still struggle every day to be like other "normal" middle-aged adults. I currently take four different kinds of medications to help treat both my conditions. I try to be more sociable with people and I constantly try not to ritualize when I groom or clean myself. I am writing this article in the hope that others may understand that both Schizoaffective Disorder and OCD are a lifetime struggle and, while both conditions can be treated, neither can be cured.

My OCD started when I was 11 years old. I had an incredibly long and tedious grooming schedule that robbed me of several hours of my day: I would take hour-long showers, wash my hair so much that I would strip it of its natural oils, and wash my body so much that my skin would crack. When I entered high school I developed even more problems. I started a checking schedule before bed, which caused me to lose hours of sleep and go to school every day looking like a zombie. I knew that my anxiety and fears were unfounded and that I was only causing more problems for myself by losing needed sleep, but I just couldn't stop.

My grades started to slip in high school, too. I was so consumed with ritualizing that I would constantly miss the bus that brought me to school, and I never had enough time to study after school because I was locked in my compulsive behaviors and intrusive thoughts, which took up a good three to five hours of my school and work day.

The symptoms of my Schizoaffective Disorder were another problem throughout my late teens and early adult years. In high school, I was paranoid that people were out to punish me; I thought I was a Communist spy working for the Soviet government, and I had delusions that I was a supreme being or religious leader who could work miracles. I have to say, now, though, because of better and newer anti-psychotic medications, that I am talking to people more and not afraid to make friends with people.

When I was 20 years old, my dad took me to a psychiatrist for treatment of my OCD, and when I was 25 years old I applied for Social Security Disability. I have been on Disability ever since, and I have been on a number of anti-depressant, anti-anxiety, anti-psychotic, and mood stabilizer medications. I even contacted the services of a psycho-social rehabilitation program in Chicago called Thresholds to help me find a job, obtain a good psychiatrist, and help get me off of bad, harmful and unhelpful medications.

For two months in 2004 I was hospitalized at Rogers Memorial Hospital in Oconomowoc, Wisconsin. The hospital has an intensive treatment program for OCD sufferers like me using exposure and response prevention and cognitive behavior therapy. The residents and I would spend about three-fourths of the day doing exposure exercises to reduce our anxiety and the rituals that we had when we came into the hospital. The rest of the day was devoted to cognitive therapy approaches to OCD, including ways to change our negative thought patterns with regard to OCD. I found the program to be extremely beneficial, and I was actually able to reduce my grooming schedule to a manageable half hour.

Once I had cut down the time I spent on rituals, I was able to start attending South Suburban College in South Holland, Illinois. I started taking prerequisite courses in the medical coding and billing curriculum and I even made the honor roll. Moreover, I saw a psychologist in Chicago, Illinois for over two years and even tried working again as a volunteer at my local hospital. My psychologist was extremely helpful in helping me find ways to reduce my OCD negative thought patterns, eat properly, live independently, and increase my vocational and social skills. Although I was making good gains trying to put my life on track, my depression worsened and I was hospitalized for a suicide attempt in June 2007.

(continued on p. 18)

(My Life, continued)

After I was discharged from the hospital I became a caretaker for my dad, as he had just been diagnosed and treated for Chronic Lymphocytic Leukemia. My father's battle was very difficult, and I had an extremely rough time with depression at that time. However, despite the extra stress and anxiety that came with coping with my father's condition, I continued to do well with my shorter grooming regimen. I now see a psychologist in Homewood, Illinois who is helping me with cognitive therapy approaches to OCD and ways to budget my time for studying, exercising, doing independent living tasks, going to social events, and increasing my vocational skills. I am currently working with the Illinois Department of Human Services, Division of Rehabilitation Services, in Chicago Heights to get myself prepared to work again.

Even more, I am still attending school part-time at South Suburban College, having almost completed my medical coding and billing certificate program. I am also trying to obtain my associate degree in liberal arts and sciences at a local community college. I am thinking about entering a bookkeeping business with my sister where I would do something detail-oriented like data entry, a job well-suited for OCD sufferers. I also am thinking about working for my local U.S. Postal Service as a data conversion operator. I still attend Thresholds, the psycho-social rehabilitation program in Blue Island, Illinois, to obtain psychiatric and vocational services.

In conclusion, I have come a long way with my OCD and Schizoaffective Disorder. I still have much work to do to get myself working again, where I can get off of Social Security Disability permanently someday. It is my hope that fellow OCD sufferers can benefit from this essay. The struggle with OCD and Schizoaffective Disorder is a lifetime struggle and, while I have improved substantially, I still know that both disorders will always be a part of me.

Worry Wanders Where Worry Wants

By Jason Silverberg

Worry wanders in the blackened pit
That is the aching heart.
She searches for weakness,
That horrible bleakness,
That gave her her galloping start.

Sullen and somber she unsheathes her hunger
And approaches this wall of glee.
She scratches away
At the innards of day
And smothers what used to be free.

Worry wanders where Worry wants.
That is a sacred truth.
She burrows, she bites,
She seeks out and fights
All those she sees near her booth.

She beckons us closer and feeds us by hand
With falseness and chicanery.
Never to budge,
And not one to judge
She takes all those that she can see.

Worry steals souls. She rips them and melts them
And drains them all down the sink.
Though she seems strong
To win shant take long
For all you need do is to think.

Forget, forget! All her cunning ways and
The battles that used to be fought
Believe you are stronger
And fear her no longer
She cannot compete with your thought.

If you would like to submit your personal story or creative writing to the OCD Newsletter, please send as a Word attachment to info@ocfoundation.org, with the subject reading, "FROM THE FRONT LINES."

BULLETIN BOARD

OCD Continuing Education Course in Holyoke, MA

Mark Your Calendars for the upcoming 2008 Annual Psychiatry Conference, hosted by the Bay State Medical Center. Continuing education credits are available for physicians, psychologists, social workers, and nurses.

Obsessive Compulsive Disorder: An Advanced Practice Seminar

Location: The Log Cabin Banquet and Meeting House, 500 Easthampton Road, Holyoke, MA

When: November 7, 2008, 8:00 AM – 4:15 PM

For more information, visit: www.baystatehealth.com/learn or call 413-322-4242.

Online Survey on the Sleep Habits of Children

Surprisingly little is known about the typical sleep habits of children, although it has been shown that disturbed sleep behavior may exacerbate already existing problems in children. Dr. Richard Frye at the Health Science Center at Houston is inviting parents and caregivers of children to complete an online survey about their child's sleep habits. Parents are welcome to complete the survey for each child, whether or not the child has a diagnosis, and all diagnoses are welcome. This survey will help us better

understand typical sleep behavior in children, and the information gathered will be invaluable in helping diagnose sleep disorders in children, and guide parents in regards to normal childhood sleep behavior.

The survey can be found here: <http://www.surveymethods.com/EndUser.aspx?B195F9E1B2F3EDE3>

If you have any questions, please contact Laura deSouza at Laura.deSouza@uth.tmc.edu or (713) 500-3236.

Does Your Child Need to Do Things Over and Over Again?

Does he or she have recurrent and bothersome thoughts or images? Does your child repeatedly check or arrange things, have to wash his/her hands repeatedly, or maintain a particular order? Do unpleasant thoughts repeatedly enter your child's mind such as concerns with germs or dirt or needing to arrange things just so?

If this sounds familiar, your child may have a treatable problem called Obsessive Compulsive Disorder (OCD). Past research has found that a form of cognitive therapy, called Exposure and Response Prevention Therapy, is helpful in as many as 85% of children with OCD. We are interested in determining if adding a medication called D-Cycloserine improves the effectiveness of Exposure

and Response Prevention Therapy in children with OCD.

You must be between the ages of 8 and 17 years old to be eligible for this study. If you are eligible, 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 8 weeks. There will also be 3 psychiatric evaluations that take place. Study medication, treatment, laboratory tests, and the evaluations will be provided at no charge. Participants will also receive financial compensation for their time. If interested, please call Dr. Eric Storch of the University of South Florida at (727) 767-8230.

UCLA Research Study on the Genetic Factors of OCD

This UCLA Research Study, conducted by James McCracken, M.D., is investigating genetic factors that may increase the risk for OCD. We are seeking help from individuals with OCD (adults and children 8 years-old and up) and their parents to participate in this study. Participation involves an interview and blood draws, you will be compensated up to \$145. Please call (310) 206-1350 for more information.

Compliance with Solicitation Regulations

The Obsessive Compulsive Foundation, Inc. ("OCF") is a Connecticut not-for-profit corporation, with its principle office in Boston, MA. 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 treatments for 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 112 Water Street, Boston, MA 02190. 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 Boston, MA or by contacting its Executive Director at (617) 973-5801. 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 the 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.

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