OCF Obsessive Compulsive Foundation

OCD Newsletter

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Come to B'Town for the 15th Annual OCF Conference

By Denise Egan Stack, LMHC

The 15th Annual OCF Conference will be in Boston this summer from August 1-3 at the Renaissance Boston Waterfront Hotel. The schedule has been set and we believe that, yet again, the conference will be a gathering place for everyone in the OCD community – consumers, families, treatment providers and researchers.

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OC Foundation Announces Research Award Winners for 2008

The OC Foundation is committed to finding and promoting effective treatment for everyone with OCD. To further this mission, the Foundation funds 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. Since 1998, OCF has funded over $2 million in research. The OCF recently announced its 2008 Research Awards:

$37,642 to Antonio Mantovani, M.D., Ph.D.
Columbia University Medical Center

Dr. Antonio Mantovani

Project: Optimization of Transcranial Magnetic Stimulation (TMS) in Obsessive-Compulsive Disorder (OCD): A Sham Controlled Randomized Clinical Trial of MRI-Guided TMS

$38,873 to Catherine R. Ayers, Ph.D.

Dr. Catherine R. Ayers

University of California San Diego, Department of Psychiatry
Project: Treatment of Compulsive Hoarding in Older Adults

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Please Contribute to the OCF Research Fund

Message From the Co-President

Dear Friends,

At our March 29, 2008 Board Meeting, a new slate of officers was voted into office. For the first time, there will be two Co-Presidents, Diane Davey and me. I will continue working with the Foundation while we transition from New Haven, Connecticut to Boston, Massachusetts but will step down after the 15th Annual OCF Conference takes place here. In addition to her new role as President, Diane is a Co-Chair of the Conference with Denise Egan Stack, another OCF Board Director. Chris Vertullo, who has held the position of Secretary for a number of years, will become Vice President; Jan Emmerman, former OCF President, will replace Chris Vertullo as Secretary, and Michael Stack will oversee the Foundation's income and expenses as Board Treasurer.

As I previously mentioned, the Obsessive Compulsive Foundation's 15th Annual Conference will be on the east coast this year, August 1-3, 2008 in Boston, Massachusetts. The Renaissance Boston Waterfront Hotel, a Marriott Rewards Hotel, was completed just three months ago and offers state-of-the-art technology. The hotel is centrally located to major highways, subways, and Logan airport. The Atlantic Ocean is a few steps away from the hotel and while it may be picturesque, it is not for swimming. Don't worry, the hotel offers an indoor pool.

I had the pleasure of visiting the site for this year's Conference and I must say that the location is terrific! It is situated in the Boston Seaport District, a newly developed area that offers the Boston Convention Center, high-rise condos, and for art lovers, the new Institute of Contemporary Art. Within walking distance of the Renaissance Hotel, there are an abundance of restaurants: Salvatore's, Aura (in the Seaport Hotel); Legal Test Kitchen, Anthony's Pier 4, the Barking Crab and 606 Congress Street in the hotel. Just to mention a few.

If you want to take a break from the Conference, there are lots of things to do: take a Boston Harbor Cruise that features whale watching, ride a Duck Boat on the streets of Boston and on the local waterways, walk the Freedom Trail, or visit the New England Aquarium where you are treated to walking around a giant saltwater tank that contains sharks, turtles and smaller reef-living fish. You can also ride the subway to the Boston Science Museum or to the Museum of Fine Arts.

On a personal note, I am excited to see that the Conference is returning to Boston. The last time it was here, I had just found out that my son had OCD and felt confused and alone. For those of you who will be attending for the first time this August, may you feel as welcomed and supported as I did back in 1995.

I hope that after reading Denise's article in this OCD Newsletter about the Conference, you will decide to join us at the 15th Annual OCF Conference in Boston, Massachusetts. If you are a mental health professional, it is a chance to get together with your peers and to earn Continuing Education Credits. If you know someone who has OCD and wants to find out what can be done to improve the quality of life, suggest that he or she join the OCD Community at the 15th Annual Conference. Visit the Foundation's website www.ocfoundation.org to sign up for the Conference and call the Renaissance Boston Waterfront Hotel to reserve a hotel room: 1-800-236-2427 and mention code OCCOCCA to book at a reduced rate.

Diane and Denise are working hard to put together a great Conference, and I look forward to working with Diane during this period of meaningful transition.

See you in Boston on August 1st.

Best Regards,
Joy Kant
Co-President, Board of Directors
Obsessive Compulsive Foundation

OCD NEWSLETTER

The OCD Newsletter is published six times a year.

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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, the OCF's 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 OCF also sends out Info Packets and Referral Lists to people with OCD, and sells books and pamphlets through the OCF bookstore.

Perfectionism: Are You Sure It Pays Off?

By Jeff Syzmanski, Ph.D.
OCD Institute, McLean Hospital
Belmont, MA

The "Real" Problem With Perfectionism

If you ask someone with OCD about the payoffs for engaging in compulsive behavior (what desired *outcomes* do you get), he or she will typically respond by saying: "It is the only way I know how to reduce my anxiety." If you ask about the costs of compulsive behavior (undesired *outcomes*), he or she readily acknowledges a long list including loss of time, money, jobs, school, accomplishments, relationships, independence, etc. Systematically weighing out the positive and negative consequences of a behavior in this way is a Motivational Interviewing (Miller & Rollnick, 2002) strategy that therapists use to help individuals generate motivation to give up undesired behavior (in this case compulsive behavior). When you help people see that their current behavior works more against them than for them (over the long-term they recognize that their anxiety is increasing not decreasing), you have an opportunity to encourage them to try something different.

Try this same strategy with perfectionists: "What are the payoffs of your perfectionistic behavior?" You get a much different and longer list of positive *outcomes* than for compulsive behavior: good grades in school, special recognition by a boss, praise from others, feelings of accomplishment, etc. You then ask, "What are the costs of your perfectionism?" In this case, you typically get an equally long list of negatives: time consuming, anxiety provoking, interpersonal conflict with others, low self-esteem ("nothing ever feels good enough"), etc. This is a trickier situation because perfectionists, on average, see their perfectionism as something they like and value about themselves even though they are able to recognize the costs. However, if you challenge their perfectionism, they typically feel misunderstood or believe that you are asking them to "just be average."

Separating Intentions, Strategies, and Outcomes

If you ask perfectionists about the intentions of their perfectionism ("What do you *want* to happen?"), what you commonly hear is a need to be seen as competent, wanting to feel satisfied with something they've accomplished, or wanting to stand out. Typically, perfectionists think that an attack on their perfectionism is an attack on their goals or values (that is, their intentions or what they want). Therefore, it is important to highlight that you agree with them that the problem is not with their intentions; it is with their strategies. Strategies in this case are what perfectionists use to express their intentions in the hopes of translating them into desired outcomes. For example, if someone wants to express the *intention* of feeling competent at work he or she may adopt an all-or-none *strategy* (99% equals 0%) in hopes of achieving the desired *outcome* (praise by the boss, sense of accomplishment). Perfectionists are able to recognize this reasoning and also recognize the low probability (but very powerful) payoff of this strategy. However, they also have a hard time letting go of this strategy. Other *maladaptive* perfectionistic strategies with poor payoffs include:

Rigidly Following the Rule

Perfectionists typically describe that their behavior and performance "must" adhere to a rule or standard about how a task should be completed. You hear perfectionists say; "It *has* to be done this way" or "Do things right or don't do them at all." Perfectionists report that they usually are identified by others as being detail-oriented and in some cases praised for this attribute. However, others also describe them as being controlling and rigid.

Everything is Equally Important

Because perfectionists want to do everything well, they have a difficult time prioritizing tasks. All tasks seem equally important, and the same level of detail, effort and energy is brought to all tasks. If you asked a perfectionist to identify some tasks to complete at 100%, some at 80%, and some at 50%, they have a difficult time moving tasks out of the 100% category.

Mistakes are Catastrophic

Perfectionism can be thought of as a phobia of mistake making. Perfectionists will go to great lengths to hide perceived or actual errors or mistakes from others. They also tend to overestimate the consequences of making mistakes. It is difficult to give perfectionists constructive feedback as they equate something less than positive being said about them or their performance as an indication of a lack of respect or liking on your part.

Repetition Until it Feels/Looks/Sounds "Right"

Because tasks have to be without mistakes and feel/look/sound "right," perfectionists tend to over edit, review, and repeat compulsively. This behavior is also intermittently reinforced as a teacher or boss will say that it was the best paper/report in the class/office. It is unacceptable for a perfectionist to let others see "rough drafts" or "works in progress."

Missing Deadlines and Procrastination

Procrastination goes hand-in-hand with missing deadlines and is fueled by the belief that one should "Do it right or don't do it at all." Perfectionists are shocked to hear that they are perfectionists, because "My room/desk is always a mess." If you ask them why it's a mess, they say that in order to clean it up the "right way" it would take enormous energy and effort they feel they don't have. So they wait for a burst of energy or motivation, then work multiple hours without a break until exhausted, only to be dissatisfied in the end because they will still see something done "imperfectly." These strategies and outcomes are remembered the next time the project comes up (e.g., cleaning their room), so avoidance and procrastination kick in as the person says, "I just don't have the motivation or energy to clean my room. I must be a lazy person."

Adaptive vs. Maladaptive Perfectionism

As an alternative to the above listed *maladaptive* perfectionism strategies (strategies with good intentions but poor outcomes), *adaptive* perfectionism strategies include prioritizing based on values, experimenting/risk-taking, recognizing diminishing returns, fighting procrastination, and using others as models.

Prioritizing Based on Values

If anxiety is your decision-maker ("I have to do well at everything or it is catastrophic"), then you waste enormous amounts of time on less important, valuable tasks. There are limits on time, resources and energy; and, if you choose to spend these on one task, it takes away from your ability to devote them to another task. For example, if your anxiety drives you to excel at everything, then being a good parent may end up being on par with being the best sock drawer organizer in the world. Again, your anxiety/perfectionism is telling you that you do have the *time* to do everything and to do everything well. However, your experience does not bear this out. You have good intentions, but poor outcomes. In Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy, Stephen Hayes (2005) makes the argument that people should let their decisions and behaviors be dictated by their values (in contrast to anxiety). One way to tap into these values is to write your own eulogy. That is, if you projected yourself into the future and look back, what would you want your life to have stood for? What do you want to be remembered for? Based on this then, you begin to form your "A" list (tasks to be completed at or near 100%), a "B" list (tasks completed at 80%), a "C" List (tasks completed at 50%), and an

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How To Access and Understand Your Mental Healt

By Sarah Allen Benton, LMHC, and Denise Egan Stack, LMHC

Each insurance company has its own system in place for obtaining mental health benefits and referral information. However, there are certain terms and procedures that are common to many and they are listed below in hopes of helping you navigate the often complicated process of accessing your mental health benefits.

This information is offered as suggestion only. We have purposely excluded information on Medicaid and Medicare in this section.

Step 1: Look on the reverse side of your insurance card and locate the "mental health/substance abuse" phone number. If this number is not on your insurance card, then look for the "customer service" phone number. When you call either of these phone numbers, there are two main pieces of information that you should obtain:

• Benefit information

• Mental health provider and/or facility referral names and contact information

If your medical benefits are issued through one company, do not assume that your mental health benefits are administered through the same company. For example: some Blue Cross/Blue Shield plans have mental health benefits contracted through Magellan, a completely different company.

Step 2: Before calling your insurance company, determine what level of care you will need to appropriately treat your mental health condition. You may obtain this information from a current mental health provider, primary care doctor recommendation, research on your condition and/or by consulting with a mental health professional at your insurance company. The terminology for levels of care may differ between insurance companies; therefore, we have listed a brief description of the most common levels of care, ranked in order from less to most intensive:

• Outpatient individual therapy: Patients see a therapist for individual sessions as frequently as determined by an initial psychological assessment, generally one or two times a week for 45-50 minutes.

• Intensive outpatient: Patients attend several groups and one individual session per day several days per week.

• Partial hospitalization: This level of care is sometimes called "day treatment." Patients attend treatment during the day at a mental health treatment facility or hospital, usually from 9am – 5pm, up to five days a week.

• Residential: Patients are treated while residing voluntarily in an unlocked mental health treatment facility or hospital unit. (Examples: MGH/McLean OCD Institute, Roger Memorial Hospital's OCD Residential Program, Menninger Hospital's OCD Residential Program)

• Inpatient: This is the highest level of care for a mental health condition. Treatment is provided on a locked unit in a psychiatric hospital on a voluntary or sometimes involuntary basis. Patients are admitted into this level of care if they are suicidal, homicidal or are unable to care for themselves due to their psychiatric condition. The goals of inpatient treatment are to stabilize the patient, which generally takes several days to a week, and then transition the patient to a lower level of care.

Step 3: When calling your insurance company to obtain benefit information, follow the telephone prompts for "members" and then "obtaining benefit information." Once you reach a live service representative, you will be asked to answer a series of questions in order to identify yourself (social security number, member ID#, date of birth, cardholder's address). After you have identified yourself, there are several questions that you are going to want to ask the representative:

• What are my benefits for the level of care that I need (see Step 2 list)?

Specifically, you will want to ask what your "in-network" benefits and "out of network" benefits are. It is generally more cost effective to utilize in-network benefits and most HMO plans do not offer out of network benefits. In order to utilize your in-network benefits, you must choose a provider or treatment facility that is participating in the insurance plan. These names can be obtained through your insurance company and this process is described in Step 4. If the provider you wish to see is not covered by your insurance company's network then ask the insurance company if they will make a "single case agreement" with the out of network provider. The most effective way to do this is by making the case that the provider offers an expertise that is not offered in its network of providers. While we know of this happening on several occasions, it does not happen often.

The benefit description will contain several terms that are important to understand:

• You will need to know the number of therapy sessions or days of treatment per calendar year that your plan covers. You should ask if there is the option for "parity" and if so, for what mental health conditions. Parity would allow your mental health provider to determine if you have a biological condition that requires more sessions or a longer hospital stay than your plan provides. If you have parity in your plan then your insurance company will allow for more, or even unlimited, sessions/days. Most insurance companies that we have worked with consider OCD a biological illness, and therefore, parity applies.

• Deductible: the amount of money that you have to pay out of pocket before your insurance company begins to pay.

• Co-payment: the flat fee that you must pay each time you have a session (generally it is between $5-20). Your insurance company pays for the remainder of the charges.

• Is authorization needed to start treatment at the level of care I think I need? You may have certain insurance benefits in your policy, but that does not mean that the insurance company will let you use them at any given time. If authorization is needed then it is important to ask what phone number to call to obtain authorization and how soon prior to the start of treatment you should call. You will need this information for Step 5.

Step 4: Once you have obtained benefit

h Benefits and Obtain Referrals

information, you will need to find out how to obtain a referral list of mental health providers and/or treatment facilities. The criteria that you should have in mind during this process are:

• What type of mental health provider are you looking for? Are you looking for a psychologist, licensed clinical social worker, licensed mental health counselor or psychiatrist? See credentialing information below for more information on different types of mental health providers.

• What type of treatment facility you are looking for (if any)?

• What specialization would you prefer the provider have experience with (OCD, substance abuse, eating disorders, anxiety disorders)? If OCD is not a choice, consider working with someone who specializes in anxiety disorders.

• What gender do you prefer your provider be?

• What zip code you would like your provider or treatment facility to be located in and how many miles you are willing to travel to get there? There are generally three ways to acquire this referral list:?

• Ask the insurance representative to verbally list the names, addresses and phone numbers of providers and/or treatment facilities that fit your criteria.

• Ask for the company website address in order to print out a list of providers/treatment facilities yourself. If you choose to do so, we suggest that you initially access the website while you are on the phone with the insurance representative so that he/she can guide you through the site.

• Some insurance representatives will conduct the website search for you and then email or fax the list to you.

Step 5: Once you have received benefit information and picked a treatment provider/treatment facility, you may need to call your insurance company to get authorization to use your benefits. You should know whether or not you need authorization based on the information you gathered when you initially called your insurance company to obtain benefit information (see Step 3). For example, if you have severe OCD, have been accepted into the MGH/McLean OCD Institute for residential treatment and have residential benefits under your insurance policy but need authorization to start your care, this is the time to get authorization. Sometimes your insurance company will give you, the subscriber, authorization, and other times they want to hear from your treatment provider/treatment facility at the time of admission.

• If you are denied authorization to use your benefits, you, as a subscriber to any type of insurance, have a right to appeal the decision. You should ask, "What is the appeal process?" Generally, there are several levels of appeal to pursue which may include you or your treatment provider writing letters or making phone calls on your behalf. If you are going to pursue an appeal, it is important to get information about timelines for appeal. Also, be sure to document content of all calls (date, time) and the names of the people with whom you have spoken.

• Don't forget, the human resources department where you work may provide assistance to you during an appeal process.

• If you have exhausted all levels of appeal through your insurance company and you are still denied authorization, there may another step to take, depending upon the state in which you live. Contact your state insurance commission to determine if they might be of help to you. According to: www.patientrights.com, state insurance commissions "are the state government bodies responsible for regulating insurers and health plans' activities. Most have consumer complaint processes." You may appeal to your state insurance commission, which may issue an independent ruling that your insurance company is required to follow.

• If all else fails, and you consider suing your insurance company for insurance coverage, we recommend you seek legal representation.

Register for the 15th Annual OCF Conference Now!

Anguish

By Shirley McMahon, MD

I have heard the stories,
of troubled souls
fixedly looking inward,
weighing good against evil,
uncertain if what seemed
real was so . . .
who matched fears with
magical safeguards
warding off danger with
extreme caution
juggling excessive guilt,
overzealous in concern
that none should be harmed
by either direct action
or failure to act . . .
these
who washed until they bled
who uttered endless prayers
who repeated ordinary actions until
perfect
who rescued useless objects
who scoured their thoughts in guilt
who checked and checked and . . .
who were alone
who slept for relief, or didn't sleep
who could not cook or eat
who dared not pass a certain place
who broke off family ties
whose anger and desperation overwhelmed them
whose anxiety allowed no reasonable
thought or action to be
vouched safe.

These are the ones who must do the
most feared thing in order
to break free
and prove the fears to be unfounded
aberrations
of a malfunctioning brain.

Research Digest

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

*This **Research Digest** presents studies showing that treatment of children with OCD largely reverses abnormalities in neurologic psychological tests and that atypical antipsychotics, risperidone and olanzapine, added to standard medication treatment with potent serotonin reuptake inhibitors (SRIs) helps almost half of patients who had not done well with SRIs alone. It also summarizes interesting studies in pathological skin picking and body dysmorphic disorder (BDD), including BDD's high prevalence of 15% in people with OCD and confirms the general lack of benefit of cosmetic surgery for BDD.*

Changes in cognitive dysfunction in children and adolescents with obsessive-compulsive disorder after treatment

Journal of Psychiatric Research, 42:507-514, 2008, S. Andres, L. Lazaro, M. Salamero et al.

Neuropsychological tests were administered to 29 children and adolescents with OCD, before and after 6 months of naturalistic treatment, and to 22 healthy subjects of similar age. Before treatment, the OCD group performed worse on some tests of memory, speed of information processing and executive functioning than the normal control group. After six months of treatment, test assessments were similar between the two groups. Patients received medication treatment (serotonin reuptake inhibitors) and counseling, and a majority of patients also received cognitive-behavioral therapy. Importantly, after 6 months of effective treatment, these children and adolescents had functioning similar to the healthy control group.

8-week, single-blind, randomized trial comparing risperidone versus olanzapine augmentation of serotonin reuptake inhibitors in treatment-resistant obsessive-compulsive disorder

European Neuropsychopharmacology, 18:364-372, 2008, G. Maina, E. Pessina, U. Albert et al

Adding an antipsychotic medication to serotonin reuptake inhibitor (SRI) medications has been an effective strategy when OCD does not respond to monotherapy with SRIs. This study evaluated effectiveness and side effects of two atypical antipsychotic medications, risperidone (Risperidal) and olanzapine (Zyprexa), added to SRI medications. After a 16-week trial of SRI monotherapy, 50 of 96 subjects were classified as having less than 35% reduction in Yale-Brown Obsessive-Compulsive Scale scores. These 50 subjects were randomized to receive risperidone (1 to 3 mg/day) or olanzapine (2.5 to 10 mg/day) added to their SRI medication. After 8 weeks of combined treatment, approximately 50% of patients in both groups improved significantly. Although equally effective as augmenting drugs, there were differences in side effects. Risperidone was more often associated with inner tension and amenorrhea (menstrual dysfunction), whereas olanzapine was more often associated with weight gain.

Clinical characteristics and medical complications of pathologic skin picking

General Hospital Psychiatry, 30:61-66, 2008, B.L. Odlaug and J.E. Grant

Pathologic skin picking (PSP) is a disorder of compulsive picking of skin to the point of causing tissue damage. This study assessed 60 individuals with PSP. The average age of PSP onset was 12.3 ± 9.6 years. The face was the most common area picked, the majority of individuals picked from more than one area, and individuals picked with full awareness of their behavior the majority of time. Subjects reported picking an average of 108 minutes each day, with some individuals spending 6-8 hours picking each day. Although most individuals used their fingernails to pick, 28% used tweezers and 13% used knives or pins to pick and these items were not sterilized prior to use. Scarring, skin ulcerations and infections were common. Approximately one-third of individuals had experienced an infection that required treatment with antibiotics. Few individuals had ever sought psychiatric treatment for their behavior. Trichotillomania (36.7%), compulsive nail biting (26.7%), depression (16.7%) and OCD (15%) were the most common co-occurring mental disorders. The prevalence of OCD was 7 to 8 times greater in these individuals with PSP than in the general population where the prevalence is 2-3%, supporting a link between these disorders. Surprisingly, only 5% of the subjects had body dysmorphic disorder (BDD). An earlier study had found almost half of individuals with BDD compulsively picked skin at some point in their lives. Researchers concluded that PSP is time consuming, frequently associated with medical complications, and research is needed to improve patient care.

Body dysmorphic disorder and cosmetic surgery: evolution of 24 subjects with a minimal defect in appearance 5 years after their request for cosmetic surgery

European Psychiatry, 22:520-524, 2007, J. Tignol, L. Biraben-Gotzamanis, C. Martin-Guehl et al.

Body dysmorphic disorder (BDD) is characterized by obsessions with an imagined or slight defect in appearance. Although recommended treatments for BDD are selective serotonin reuptake inhibitors or cognitive-behavioral therapy, individuals often seek cosmetic surgery to fix their imagined or slight defects. This study evaluated the effect of cosmetic surgery and the stability of BDD diagnosis in 24 patients with a minimal defect in appearance, comparing patients with BDD (N=10) and without BDD (N=14), 5 years after their request for plastic surgery. Seven of the BDD subjects had received cosmetic surgery versus 8 of the non-BDD subjects. Patient satisfaction with surgery was high in both groups. However, at 5-year follow-up, 6 of the 7 operated on BDD patients still had a BDD diagnosis, had high levels of handicap and psychiatric comorbidity compared to the non-BDD subjects. Only 1 patient no longer had a BDD diagnosis at follow-up; all other patients who had received surgery still had a BDD diagnosis and all but 1 of these had developed a new site of preoccupation. Moreover, 3 non-BDD subjects had developed BDD at follow-up. This study confirmed that cosmetic surgery was not effective for BDD despite declared patient satisfaction. Patients' declared satisfaction with surgery may contribute to plastic surgeons not adhering to the general contraindication of cosmetic surgery in BDD. This study is another confirmation that cosmetic surgery is not an effective treatment for BDD.

Severe obsessive-compulsive disorder with and without body dysmorphic disorder: clinical correlates and implications

Annals of Clinical Psychiatry, 20:33-38, 2008, S.E. Stewart, D.E. Stack and S. Wilhelm

This study looked at the co-occurrence (comorbidity) of body dysmorphic disorder (BDD) in patients with severe OCD. A high prevalence of BDD, 15.3%, was found in 275 patients at the McLean-Massachusetts General Hospital OCD Institute, a residential treatment program. Patients with both BDD and OCD (N=42) were compared to patients without BDD (N=233). Patients with comorbid BDD were younger, more likely to be female, less likely to be married, and had more severe depression and higher rates of substance abuse. Additionally, OCD patients with BDD had increased hoarding, symmetry, reassurance-

seeking and checking symptoms. The response to OCD treatment, cognitive-behavioral therapy and medications, was similar between the groups. Based on their findings, researchers state it is important to consider comorbid BDD, especially for young female patients with early onset OCD. If a patient has both disorders, it is important to watch for worsening depression and substance abuse.

Prevalence and clinical characteristics of body dysmorphic disorder in an adult inpatient setting

General Hospital Psychiatry, 30:67-72, 2008, M. Conroy, W. Menard, K. Fleming-Ives et al.

Of 100 patients admitted to a hospital psychiatric unit, 16 (16%) were diagnosed with lifetime (past or current) body dysmorphic disorder (BDD). Before assessment for this study, only 1 patient had reported BDD symptoms to the current inpatient psychiatrist. Most patients had not mentioned BDD symptoms due to embarrassment, fears of being judged negatively or beliefs that the clinician wouldn't understand. Inpatients with BDD had more severe depressive symptoms. Additionally, all patients with BDD reported a history of suicidal thoughts and 15 patients had attempted suicide. Researchers summarized that BDD appears relatively common, but is underrecognized in psychiatric inpatients. Therefore, it is important to screen hospitalized psychiatric patients for BDD.

Early-onset obsessive-compulsive disorder and personality disorders in adulthood

Psychiatry Research, 158:217-225, 2008, G. Maina, U. Albert, V. Salvi et al.

Adults with childhood onset OCD (N=33) were compared to adults with later onset OCD (N=69), in terms of having comorbid personality disorders. Childhood onset was defined by age less than or equal to 10 years of age and later onset was defined as age greater than or equal to 17 years of age. Adult patients with an early onset of OCD symptoms had a significantly higher occurrence of obsessive-compulsive personality disorder (OCPD): 48.5% of patients versus 20.3% of patients with later onset OCD. This was the only personality disorder difference found between the two groups. Researchers suggested reasons for this higher occurrence. Development of OCPD could occur as individuals cope with the need for perfection and control caused by their OCD. Alternatively, child-onset OCD could be a specific OCD subtype. Study findings suggest that the risk of developing OCPD in adulthood may be increased by an earlier age of onset of OCD.

MARK YOUR CALENDARS! FOR THE 2008 OCF-SPONSORED BEHAVIOR THERAPY INSTITUTE

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

July 25, 26, & 27, 2008

Alta Bates Summit Medical Center

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Faculty

Eda Gorbis, Ph.D.
Founder and Director, Westwood Institute for Anxiety Disorders
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Lorrin Koran, M.D.
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Paul Munford, Ph.D.
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Director, San Francisco Bay Area Center for Cognitive Therapy
Clinical Professor of Psychology, University of California – Berkeley

C. Alec Pollard, Ph.D.
Director, Anxiety Disorders Center, Saint Louis Behavioral Medicine Institute
Professor of Community and Family Medicine, Saint Louis University

Eric Storch, Ph.D.
Assistant Professor of Psychiatry and Director of Cognitive and Behavioral Research, OCD Program, University of Florida

Maureen Whittal, Ph.D.
Director, Anxiety Disorders Unit, Vancouver Hospital
Clinical Instructor of Psychiatry, University of British Columbia

Registration Fees for this BTI are $250.
For More Information call (617) 973-5801 or visit the OCF website: www.ocfoundation.org

Come to B'Town

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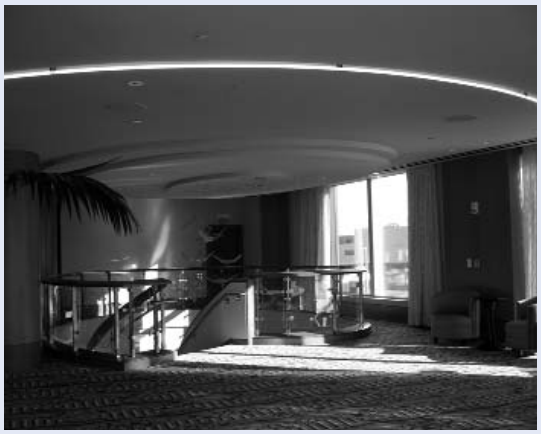
As in previous years, the OCF will be hosting Art and Activity Rooms for children and teens. The rooms will be staffed by

Jenifer E. Waite Wollenburg and Katy Peroutka, art therapists from Rogers Memorial Hospital, and will offer a variety of activities such as: jewelry making, mask making, social games and the creation of the Annual OCF Conference Mural. Adolescents (13 and older) will have many chances to socialize and make friends who they can keep in touch with after the Conference. Children (6-12) will have opportunities to participate in projects that support themes related to the presentations at the Conference.

The schedule includes over ten support groups designed specifically for people with OCD and parents and siblings of people with OCD. In addition, Jonathan Grayson and his team will be running the 8th Annual OCF Virtual Camping Trip, an experiential workshop in which participants will experience the exhilaration of conquering OCD fears in a group. This is an extremely popular workshop that has helped hundreds of people over the years – do not miss it!



There will be over 60 sessions for consumers, which includes the "Ask the Experts Goes Live!" session with Drs. Jenike and Claiborne and presentations on OCD in the workplace, perfectionism, contamination, scrupulosity, intrusive thoughts, coaching for families and accepting uncertainty. In addition, Dr. Fugen Neziroglu will present a screening of the hoarding movie "My Mother's Garden" by Cynthia Lester and afterwards will present "How to Get Hoarders into Treatment."

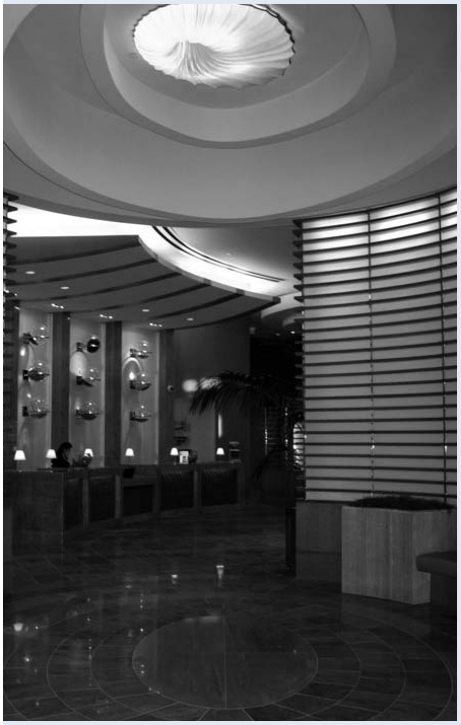
Supporting the OCF's mission to promote effective treatment for OCD, there will be over 20 sessions for treatment providers, which includes a 5-hour "Introduction to OCD and the Treatment of OCD" for professionals new to treating people with OCD. There will also be sessions on how to treat BDD, hoarding, trichotillomania, topics specific to children, co-morbid Asberger's disorder and treatment-resistant OCD in children and adults. We will be offering up to 22.5 continuing education credits for medical doctors, psychologists, social workers, professional counselors and nurses.

To honor the OCF's commitment to research, the Conference will hold its first ever Poster Session on Friday from 3-4 pm. The use of posters provides a relaxed and interactive venue for researchers and Conference participants to discuss current research and innovations related to the field of OCD and OCD spectrum disorders. In addition, the schedule includes nine research sym-

posiums which will present data on topics such as genetics, neuroimaging, neurotherapeutics, acceptance and commitment therapy for OCD, body dysmorphic disorder, medication augmentation of behavior therapy and multiple perspectives on the cognitive processes of OCD.

Also, Dr. Scott Rauch will moderate a discussion with Dr. Katherine Phillips on OCD in the DSM-V, a topic that is current and relevant to everyone in the OCD community.

Mimi and Bob Doan will run the OCF Bookstore as they have in the past, and Conference participants will be able to meet the authors of popular OCD books in our "Meet the Authors" book signing sessions.



Most importantly, this year the Conference will be dedicated to Patti Perkins, one of the founding members of the OCF. She has worked tirelessly on behalf of people with OCD over the last twenty-two years – raising awareness of the disorder, fundraising for research and providing hope and support to thousands of people affected by OCD. Without Patti, the OCF would not exist. With the recent move to Boston, Patti is stepping down as OCF's Executive Director, but she has joined the Board of Directors and will continue her work for the cause of OCD. There will be a special presentation honoring Patti before the Keynote Address, and we hope you will join us in Boston this summer to help celebrate her work.

To view the entire conference schedule and/or to register and pay for the Conference online, please visit www.ocfoundation.org.

Come to the 15th Annual OCF Conference

August 1-3, 2008 at the Renaissance Boston Waterfront Hotel Boston, MA

- There will be Workshops, Presentations and Support Groups led by clinicians, investigators and people with OCD and family members.

- This Conference is specifically designed for People with OCD, Family Members, Children, Adolescents and Young Adults with OCD and Treatment Providers.

For more information, go to www.ocfoundation.org

The Parents' List: A Good Place To Go Where People

Dear Parents,

Our list was created in January of 1999. A number of parents were participating in Chris Vertullo's OCD-L, which was the vanguard of lists for people in the OCD community. Several parents mentioned the possibility of starting our own group to focus on the issues facing parents of children with OCD. I started the group and parents began joining because of our need to relate to other parents facing the same issues with which we deal daily.

I think for most of the parents the initiation into parenting a child with OCD is traumatic. You realize that something is different. It can happen overnight and be so dramatic that it is almost otherworldly. Others only become aware of OCD after years of noting that there is something different about their child, but never quite being able to name it or connect the difference to a pattern of behavior that would include OCD, Whether the realization is rapid or takes place over time, the diagnosis of OCD, although traumatic, is almost always a source of relief. The difference has a name; there is literature to read; and mental health professionals to seek out. Hope is real. Unfortunately, many times parents feel guilty that they had seen the signs but did not recognize it was OCD until the diagnosis.

After visiting a doctor who is usually a primary care physician and receiving a referral to a psychiatrist, the process of working out a solution starts. The chronic nature of OCD becomes apparent over time and the realization that a long struggle awaits sinks in. Medications and/or therapy begin and the effort at finding something that will help your child with his/her obsessions and compulsions. Sometimes the therapy (usually CBT or E&RP) may begin without the use of medications. But so often the intense anxiety created by such therapy requires the ameliorating effects of medication to make the treatment tolerable for your child.

Medication trials are so difficult for both the parent and child because you find yourself looking for improvement that can take twelve weeks to evolve and sometimes side effects argue against continuation of the current medication. We parents are encouraged to "Stick with it," "Don't give up," etc. You come over time to an awareness of what psychopharmacology is: finding the most effective treatment with the fewest adverse side effects either behavioral or physical. This process can be successful with the first try or it may have to be repeated numerous times to find the right combination for the totally unique individual who happens to be your child. This process can often consist of one step forward and two backward. I know that many parents hesitate to report progress to the list because they know that the two steps backward are in the offing, right around the corner. But I have learned that progress for our children happens slowly; and, depending upon the severity of our child's condition, the quality of help s/he receives, and the presence of internal motivation in parent and child, things do get better.

As this process starts I believe the heaviest weight on parents can be a sense of isolation. My child has OCD. I don't know any other parents who have children who are wrestling with this problem in addition to the ordinary difficulties implicit in growing up in the world as we know it. Medical information must be kept private so the doctor who is treating your child cannot suggest that you meet other parents of children with OCD without violating the privacy of his other patients. This conundrum spawned the creation of the OCD and Parenting List. Parents found us on the internet or were referred to us by the OCF. As time passed mental health professionals began referring parents to our list. We actually have doctors who have joined as members because their child has OCD. Most members join in response to their child being diagnosed with OCD, or because they suspect that the difference they see in their child might be OCD. Public awareness has grown through the work of the OCF, increased discussion of OCD in medical literature, and the coverage that news organizations have begun to give OCD.

Our list provides an asynchronous community for parents of children with OCD. Our list exists when they press the key on their keyboard and read about the experiences of other parents; or when they press the key to send a question to the list; or when they take time out of their own struggle with OCD to help a parent who has not had as much experience as they have. We have so many members, who started out in crisis with nothing but questions and a sense of relief that they had found others who understood and empathized. Many of these parents went on to become the source of answers to questions asked by parents who joined the list later and were experiencing the same crisis and same feelings of relief at having found a sanctuary where there is information, empathy and community.

our list has generated over 66,000 emails and has over 1,600 families subscribed from all over the world. We have doctors who participate in an advisory capacity and doctors who participate as parents of their own children with OCD. Dan Geller, M.D., (http://massgeneral.org/pediatricpsych/staff/geller.html) is our participating psychiatrist. Gail Adams, Ed.D., (http://wwww.ocdawareness.com) participates as an expert on OCD in educational settings. Tamar Chansky, Ph.D., (http://worrywisekids.org) and Aureen Wagner, Ph.D., (http://www.lighthouse-press.com) participate as psychologists in private practice and authors of numerous books on the treatment of OCD in children.

Our list URL is http://health.groups.yahoo.com/group/OCDandParenting/. Our email subscription address is OCDandParenting-subscribe@yahoogroups.com. Parents may subscribe by sending a blank email to the subscription address and our list server will respond and take them through the subscription process.

As you know, OCD is a chronic disease and our children grow up. So, we have created a list for parents of adult children with OCD. The list URL is http://health.groups.yahoo.com/group/ParentsOfAdultsWithOCD/. We currently have over 140 families subscribed worldwide. Parents may subscribe by sending a blank email to the subscription address: ParentsOfAdultsWithOCD-subscribe@yahoogroups.com. The list server will respond and help them sign up.

As parents of adult children, we face many of the same questions that parents of younger children are concerned about. But the clock is running. Now it is our time to help our children before we are

Will Understand

gone and they are left without us to advocate and care for them. Some of our children are out on their own with jobs and families, but many remain at home or alone in their own residences. We parents of the older children with OCD discuss issues that may or may not lay ahead for parents of younger children with the disorder. Hopefully, with advancements in medications and treatments, OCD will become less chronic and more easily identified, treated, and quickly cured so that the process will not rob a child of his/her education and anticipated adult experiences.

The questions to the group for parents of younger children with OCD usually follow a pattern, which starts with a diagnosis (Is this OCD?) and treatment and medication questions. They want to know how to find a good therapist, what to expect in therapy, and what sort of medications have been prescribed. They are concerned about behavioral side effects from medications, the mixing of medications in an effort to augment efficacy of the individual medications prescribed, school issues resulting from OCD or comorbid conditions, and general issues regarding socialization as the child grows.

The questions to the group for parents of older children with OCD usually relate to current difficulties that an adult child is still facing with OCD. The typical severity and chronic nature of these cases and the usual history of less than successful treatment with medication and/or therapy mean that the parents are usually approaching their problem from a less optimistic perspective. A general concern about the future of their child permeates their questions, comments, and answers to questions. John Hart, L.C.P.C., from the Menninger Clinic in Houston, Texas, and Ted Witzig, Jr., Ph.D., (http://www.accounseling.org) are our list advisors. Lynn E. O'Connor, Ph. D., (http://www.eparg.org) is our list research participation coordinator. Parents of children who have experienced more successful outcomes may not be present because their children are not as disabled by OCD as the children of parents participating in this list.

Come join us on our lists. You don't need to be alone anymore.

Best regards,
Louis Harkins

Perfectionism

(continued from page 3)

"F" List (what to let go).

Experimentation and Risk Taking: Re-evaluate your beliefs about mistake making. Allow people to actually see you make some mistakes and pay attention to their reactions towards you. Ask for some feedback on "works in progress" and for collaboration and input from others about your work. Following a rule or standard may be safe and may help you avoid some mistakes, but it is also the opposite of creativity and innovation.

Diminishing Returns: More does not always mean better. Consider the following example: You ask your primary care doctor if there is something preventive-wise you can do to help decrease the chances of developing cardiovascular disease. The doctor might suggest a glass of red wine with dinner each night. You return to your doctor six months later and say: "I enjoyed the glass of wine with dinner so much, I'm up to a gallon of wine a day now!" Repetition, persistence and more effort do not always reap better rewards. The majority of the payoff for your efforts happens early in the process. Pay attention to when improvements on your outcomes are no longer matching your level of effort.

Fight Procrastination: Break larger projects down into sub-steps and do one at a time. Give yourself rewards for completing steps in a task in order to keep your motivation up through to completion of the task. Allow yourself to leave a project unfinished and come back to it another time with a fresh perspective. Don't miss deadlines: It is better to turn in rough drafts than nothing at all.

Use "Conscientious" People as Models: Identify someone in your life who shares your same goals and intentions, but who doesn't seem to be struggling as much and has better outcomes. "How is it that Sue appears to be competent, but does not have to boss other people around? What is she doing differently strategically than what I am doing?" Find out what they are doing and imitate them finding your own style or "take" on these new strategies. In conjunction with this suggestion, I also recommend that perfectionists read The Seven Habits of Highly Effective People, Covey, 1989).

Conclusions

When someone criticizes you for being a perfectionist, keep in mind that he or she may not be complaining about your desire to excel. What he or she might be highlighting is that you reconsider how you get there. Again, the problem with perfectionism isn't the desire to do well; it is the fact that perfectionists need to give up the stragegies that have a poor payoff.

OCDTribe.com, An Online Support Community

By Ryan FitzGerald

If you struggle with obsessive compulsive disorder (OCD), it may provide some comfort to know you are not alone. One in 50 adults in the United States are reported to have OCD. Imagine if you could connect with others like you, across the globe, anytime. Now you can.

OCDTribe is a *free* online support community, with thousands of members, designed specifically to connect individual with OCD from around the world. Members receive 24/7 access to the latest in social networking features such as blogs, forums, messaging, profile pages, groups, games and more. OCDTribe offers members a place to share stories, encouragement and friendship.

In addition, OCDTribe offers custom group features. If you run a local support chapter, you can post your events as well as information about your group. Create an online extension of your local chapter with your own private forum and chat, allowing your members to stay connected between sessions. You can even find new members in your area to join your group,

Members have been overwhelmingly positive about the impact OCDTribe has had on their lives. "OCDTribe has been a real gem in my therapy; it provides a huge amount of advice and support, and brings lots of like-minded people together. A lot of suffers have never known anyone who truly understands them, but this site has changed that. In addition to the support it provides, it's a good way to make good friends, very good friends. OCDTribe is such an important website for OCD sufferers, it's hard to imagine life without it now." *Billdoor79, UK*

"I've never experienced much empathy for my illness. That's why I have come to depend on the OCDTribe so much. I have made so many friends, and met so many others who have experienced the same things I have. It's nice to have a place to go and talk about the weirdness of OCD without judgment or recrimination. I really am a fan of this site!" *Litgirl, TN*

OCD can be life consuming. Many don't know there are millions of people that struggle with OCD. While medication and therapy are critical for managing OCD, many find sharing stories and encouragement with others that face OCD can make daily challenges easier. Read more about what members have to say at: www.webtribes.com/testimonials.html.

My Personal Story

Grateful...

By Joanna Proffitt

I have OCD, what do I have to be GRATEFUL for? I am grateful that my symptoms didn't develop until my late teens/early 20's. I can't imagine how painful and scary it would be to struggle with OCD as a child. I am grateful that I figured out what it was fairly quickly. I am quite resourceful and found information on OCD right after I developed symptoms. I can't imagine feeling like you were the only one with these thoughts. I knew almost immediately that I wasn't alone. I am grateful that I am able to be a "functioning" adult living with OCD. I have been able to work and have two beautiful boys. I am grateful that I don't have more symptoms, more obsessions, more compulsions. I am grateful that I can leave the house everyday if I want to. I realize that there are others who struggle much more than I do.

My OCD story began around the time that I became pregnant with my first child. I started worrying A LOT. I worried about doing something that might hurt somebody. After I had my son, I started worrying about doing something that might hurt him. I worry about leaving the iron or stove "on" or anything else that could cause a fire. The coffee pot at work is also a problem and I don't even drink coffee! I also check doors and windows, often multiple times. It is as if I don't trust myself. I know that it is completely unreasonable but that doesn't ease my mind enough to make me stop.

I have found lots of ways to cope with the disorder. I take medication. For years, I had successfully used exercise to keep my symptoms under control. Exercise produces drug-like chemicals in the brain and that were enough to keep my symptoms at bay. If I didn't exercise regularly though, I would start having problems.

When things did get difficult enough for me to want to try medication, I was lucky to have an excellent doctor. She assured me that she knew DOCTORS that had to take medication for anxiety. That is typically the way that I describe my disorder to friends and co-workers, ANXIETY. I think people tend to accept the anxiety explanation much more easily and OCD is considered an anxiety disorder.

I have also found great comfort in religion. For years I shunned organized religion, like many do. Recently, I found a church that is more spiritually based and very uplifting. When things get really difficult, I realize that God knows that I don't want to do anything to hurt anybody, that He knows the real me. I am also blessed with a wonderful partner who brings home articles on OCD for both of us to read. If the time ever comes that I feel I need to seek outpatient treatment, I am confident that I would do so. I have also felt empowered by my involvement with the OC Foundation. I want to be a part of supporting others with the disorder, education, and of course, hoping that someday there will be a cure.

Research Award Winners

(continued from page 1)

$50,000 to Sanjaya Saxena, M.D.
University of California San Diego, Obsessive-Compulsive Disorders Program
Project: Functional Neuroanatomy of Body Dysmorphic Disorder
Dr. Saxena is the recipient of the 2008 Fran Sydney Research Award.

$63,161 to Gregory L. Hanna, M.D.
University of Michigan, Department of Psychiatry

Dr. Gregory L. Hanna

Project: Error-Related Negativity in Unaffected Siblings of Youth with Obsessive-Compulsive Disorder.

$49,901 to Peggy Richter, M.D.
Center for Addiction and Mental Health, Ontario, Canada
Project: Predicting Medication Response in Obsessive-Compusive Disorder

Register Now for the Advance Behavior Therapy Institute (ATBI)
"Addressing the Need for Completeness -- Understanding and Treating 'Not Just Right OCD'"
Presenter
Laura Summerfelt, Ph.D.
Trent University
Thursday, July 31, 2008
1:00 pm -- 6:30 pm
at the
Renaissance Boston Waterfront Hotel
Registration Fee: $100.00

For More Information, Call the OC Foundation at 617-973-5801

Bulletin Board

OCD Sibling/Twin Study

Research study at the National Institute of Mental Health

Looking for sibling pairs up to age 65 where one sibling has been diagnosed with Obsessive Compulsive Disorder (OCD) prior to age 18, and looking for identical twin pairs up to age 65 where either one or both twins have been diagnosed with 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.

Obsessive Compulsive Disorder Study for Children and Adolescents

If your child or teen (ages 7-17) is suffering from Obsessive Compulsive Disorder (OCD), he or she may be able to participate in a research study at the National Institute of Mental Health (NIMH). We are investigating the medication riluzole.

Children and adolescents with a primary diagnosis of OCD, or both Autism Spectrum Disorder and OCD may be eligible. Participants will be randomized to either riluzole or placebo (pill with no active ingredient) for 12 weeks. At the end of 12 weeks, all participants will have the option of taking riluzole (no chance of placebo). A comprehensive psychiatric and medical evaluation and follow-up visits approximately monthly for 6 months, and at 9 and 12 months, are included. There is no cost to participate; travel assistance may be provided.

For further information, please call 301-435-6652 or 301-496-5323 (Lorraine Lougee, LCSW-C) or email OCDNIMH@intra.nimh.nih.gov.

National Institute of Mental Health, National Institutes of Health, Department of Health and Human Services.

Research Volunteers Needed!

Have you been diagnosed with Obsessive-Compulsive Disorder?

Do you experience symptoms such as persistent, unwelcome thoughts or images, or the urgent need to engage in certain rituals like repetitive hand washing, counting, checking, or cleaning even though you have been treated with medications?

If so, you might qualify to participate in a research study!!

To be eligible, you must also:

- Be at least 19 years old
- Be willing and able to come to the clinic weekly for 14 weeks

We offer:

$25 per visit for time and travel, physical examination, EKG, laboratory work-up, and study medication at no cost to you.
If you are interested in participating in this research study, please call the Psychiatry Research Center at 402-660-2903 or Angie at 402-345-8828 x 24
Creighton University
Department of Psychiatry
3528 Dodge Street
Omaha, NE 68131

Acamprosate (Campral) for SSRI resistant Obsessive Compulsive Disorder

The selective serotonin reuptake inhibitors (SSRIs) are usually the first line of treatment for Obsessive Compulsive Disorder. However, treatment resistance to SSRIs (Prozac, Zoloft, Paxil, Celexa, and Lexapro) is quite common and a major clinical problem. Our aim is to study the efficacy and safety of adjunctive acamprosate (Campral) in SSRI-resistant OCD. Acamprosate (Campral) is approved by the FDA, but not for the treatment of OCD. The study will involve weekly visits for 12 weeks and participants will get free medical care, study drug and a $25 stipend for each completed visit.

If you are interested in participating in the study, or finding out more about it, please call the Creighton Psychiatry Research Center at 402-660-2903 or visit our posting on careerlink.com.

Principal Investigator: Sriram Ramaswamy, MD
Creighton University
Department of Psychiatry
3528 Dodge Street
Omaha, NE 68131

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 to 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 8 weeks. There will also be 3 psychiatric evaluations that take place. Two of these evaluations will be comprehensive and take about 3 hours each (immediately before and after treatment). During each of these, the participating child will have a small amount of blood withdrawn for lab tests. One evaluation will be short and take place in the middle of treatment. 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 Florida at (352) 392-3613.

OCD and Hoarding Neuroimaging and Neuropsychology Studies

The Anxiety Disorders Center at the Institute of Living/Hartford Hospital in Hartford, CT is conducting studies of people with either obsessive compulsive disorder or compulsive hoarding including a neuroimaging (brain scan) study and a study examining problem solving abilities. Participants will receive $20 per hour. The studies are open to adults aged 18 to 65 who meet study criteria. For more information please call or email the Anxiety Disorders Center at (860) 545-7039 or adcresearch@harthosp.org

Graduate Research Study

Obsessive Compulsive Disorder and the Role Support Groups Play
Reason for the Study: I have an uncle who

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Bulletin Board

(continued from page 13)

was diagnosed with OCD about seven years ago. When he informed me he that had OCD and was receiving medical help, I had no idea what OCD was or what he was dealing with! It is because of the struggles I have seen him go through that I have decided to become a supportive family member and be there for him as he may need me. The purpose of this study is to learn as much as I can about OCD so I can help him find new ways and methods to help make his life easier. Through talking with many people who have OCD and through my research, I have discovered that OCD is a daily battle over which people have no control. Each day is a challenge and although some days may be easier than others, this is a battle many have to deal with for the rest of their lives. After attending the OC Foundation conference last summer, I learned that social support is a communication method many people with OCD turn to.

How You Can Help

I need to interview people who have OCD and fit in one of the following categories:

1) People who are participants of a face-to-face support group.

2) People who are participants of an online support group.

3) People who are not participants of any type of support group.

All questions will be based on your experiences with OCD and your views on support groups in general. Interviews will be recorded in order for me to transcribe them for my study. Your name and identity will remain anonymous at all times. You only have to give information that you feel comfortable giving. There are no right or wrong answers to any of the questions; I just want to hear how you feel and learn from you and your experiences!

If you are interested, please contact:

Allison Davis
Graduate Student
The University of Texas at Arlington
Email: allisondavis11@gmail.com
Phone: 972-841-2433

Wanted: Behavior Therapist

The Center for Behavioral Health, LLC, specializing in the treatment of OCD, anxiety spectrum disorders and depression for ages ten through adult, is seeking two licensed clinicians to fill a full time and part time position. The Center for Behavioral Health is a growing outpatient practice located 45 minutes south of Boston and 30 minutes from Cape Cod. Preference will be given to candidates with strong cognitive-behavioral skills and experience with OCD and anxiety disorders. Case supervision is available. Hours are negotiable according to personal preference however some late afternoon / evening hours are required. Proper candidate can have a full caseload quickly without the administrative burdens. Competitive reimbursement. Benefits available. Email with any further inquiries about the positions. Send CV with letter of interest to: Deb Osgood-Hynes, Psy.D., Center for Behavioral Health, LLC, 31 Schoosett St., Suite 205, Pembroke, MA 02359. Fax/phone: 781-829-0902. Email: centerforbehavioralhealth@comcast.net

Stepped Care for Obsessive Compulsive Disorder Treatment Study

The Anxiety Disorders Center at Hartford Hospital/ Institute of Living in Hartford, CT is comparing two different approaches to treating Obsessive Compulsive Disorder (OCD); one called Stepped Care treatment and the other called Twice Weekly treatment. As part of the study, participants receive Cognitive-Behavioral Therapy (CBT), which is considered to be one of the most effective treatments for OCD. Participants are randomly assigned (like a coin toss) to one of the two types of CBT treatment described below.

Twice Weekly Cognitive-Behavioral Therapy:

In this treatment, participants receive therapist-directed CBT twice per week for 8 weeks. In these sessions, participants work one-on-one with the therapist during their sessions and practice what they learn at home.

Stepped Care Cognitive-Behavioral Therapy:

In this treatment, participants are provided with a manual to develop their own CBT program. Participants also meet with a therapist 3 times over the 6 week program to help guide them. If, at the end of this first step, a participant's OCD symptoms have not significantly improved, they are invited to move into the Twice Weekly therapy described above.

Treatment as part of this research study is free of charge for those who qualify. We also offer a small monetary incentive to participants for completing follow-up assessments at one-month and 3-months after the treatment.

Basic Criteria for the treatment study:

- 18-69 years of age
- If taking psychiatric medications, must be on the same dose and medication for 4 weeks prior to starting the study and must remain on that dose for duration of the study.
- Have never had Cognitive-Behavior Therapy or Exposure and Response Prevention therapy before.

If you are interested in learning more about the study or are interested in participating, please contact: 860-545-7039 or adcresearch@harthosp.org

OCD Study at Boston University and Hartford Hospital

The Institute of Living in Hartford, CT, and The Boston University School of Social Work are conducting research to understand the features of obsessive compulsive disorder and compulsive hoarding. The study compares people with hoarding problems to those who have obsessive compulsive disorder (OCD). It is not necessary for those participants with OCD to have hoarding problems or clutter to participate. The researchers hope to learn more about why hoarding and obsessive compulsive symptoms develop, how these problems are related to other psychiatric disorders and how best to assess these problems. This information may be helpful for identifying effective treatments in the future.

Researchers are looking for people age 18 or older who have:

1. problems with excessive clutter or
2. obsessive compulsive disorder and,
3. live within forty minutes of the greater Hartford or Boston areas.

The study consists of an interview which can last about 4-6 hours and includes a diagnostic assessment about anxiety and mood symptoms and questions about clutter and acquiring. These interviews take place at the clinics and can be done on different days. Additionally, the study will include a 1-hour visit to the participant's home where the interviewer will take pictures of each room and the participant will answer questions about their home. Participants will be paid $20/hr for their time and can make up to $160.

Participants will also have a chance to take part in two other studies: an experimental task about removing clutter from their home, and another task about acquiring new items.

If you are interested in participating and have any questions, please contact Jessica Rasmussen, B.A. at Boston University at (617) 358-4213 or (617) 353-9610, or Kolette Ring, B.A. at The Institute of Living in Hartford, CT at (860) 545-7917.

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. **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.

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