OCF Obsessive Compulsive Foundation

OCD Newsletter

Volume 21 Number 4 Published by The OC Foundation, Inc. SUMMER 2007

Home Based Behavior Therapy For People With OCD

by Denise Egan Stack, MA, LMHC

Over the last ten years, I have been treating people with Obsessive Compulsive Disorder (OCD) in home and community based settings utilizing home and community based therapy (HCBT). During that time, I have found utilizing home and community based therapy to be an effective way to treat people with OCD, especially if a patient has failed several trials of outpatient behavior therapy or is transitioning from an intensive treatment setting. While HCBT offers the behavioral treatment provided in an outpatient setting (development of hierarchy, goal setting, homework assignments/review, skills training, relapse prevention plan), it differs from outpatient behavior therapy in several ways.

HCBT includes an assessment of OCD symptoms in a patient's natural environment, which is often not possible in office based therapy.This ensures a more comprehensive behavioral assessment because it does not rely on patient self-report outside of the anxiety provoking moment/environment. For example, a patient with contamination obsessions and washing/avoidance rituals at home might proceed room to room through his/her house, noting all triggers and providing an accurate SUDS (Subjective Units of Distress) rating when in actual contact with the trigger. HCBT therapists have an opportunity to probe more directly and thoroughly in the patient's natural environment, inquiring about possible avoidance behaviors or reassurance statements based on observations in the moment. This provides a more accurate picture of what the patient experiences when triggered or performing rituals. It also, I believe,

(continued on page10)

The Staff and Board of Directors of the OC Foundation want to thank the Peace of Mind Foundation for underwriting the 14th Annual Conference, and the presenters and attendees for a great Conference experience.

Self-Directed Treatment for OCD: The Irony of Doing the Opposite

by Paul R. Munford, Ph.D.

I remember a movie in which one of the characters went around asking people to define the word "irony." Although most of them seemed to know what it meant, they were unable to put it into words. Not until the end of the movie did one of them give the definition. I'm reminded of this because the continuation and elimination of OCD symptoms are perfect examples of irony or the occurrence of outcomes that are opposite to those that were intended. You have probably been steering clear of triggers for your obsessions and doing compulsions after contact with those you couldn't avoid. Ironically, instead of lessening your distress, what you have been doing is sustaining or even worsening your condition. To get out of this quagmire, you have to start doing the opposite of your strategy up until now. This means deliberately making contact with the triggers while refraining from doing compulsions. With enough exposure to the triggers, and for sufficient periods of time, you will notice that they become powerless to provoke distress, and the absence of distress eliminates the need for compulsions. See what I mean about OCD and irony? Exposure, ritual prevention, and awareness exercises are used to achieve this.

Exposure, Ritual Prevention, and Awareness Exercises

(Continued on page 11)

Message From the President

Excerpts from the President's Welcoming Address to the 14th Annual OCF Conference in Houston, Texas at The Marriot Woodlands

I, Joy Kant, President of the OCF Board of Directors, would like to welcome you to the Fourteenth Annual Obsessive Compulsive Foundation Conference in Woodlands, Texas. You may have noticed that the format of this year's conference is different from previous years.

As part of the Foundation's latest initiative to increase OCD awareness in the school systems throughout the United States, Linda McIngvale, a member of the OCF Board of Directors and Peace of Mind, put together Friday's Educational Program, which was headlined by Dr. Aureen Pinto Wagner. The purpose of the seminar was designed to raise awareness of Obsessive Compulsive Disorder among educators, helping them to recognize symptoms and to work effectively with students suffering with the illness. If you were unable to attend but would like knowing more about the program, contact Linda McIngvale or an OCF staff member. They will provide you with information as to how you could set one up in your hometown.

Ten years ago, I retired from teaching. I taught for twenty-five years and I regret to say that I had not heard about OCD until my son was diagnosed toward the end of my teaching career. In that summer of '94, I began to wonder if some of my former students had struggled with OCD in my classroom.

Now I look back and think of the child who repeatedly went to the bathroom for

(continued on page 10)

Bulletin Board

OCD And Hoarding Study

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 participants 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 a 4-hour diagnostic interview about anxiety and mood symptoms followed by a 4-hour interview about clutter and acquiring. These interviews take place at the clinics.

Additionally, the study will include a 1-hour visit to the participant's home where the participant will take part in an experimental task about removing clutter and another task about acquiring new items. Participants will also have a chance to take part in a discarding and acquisition task. Participants will be paid $20/hr for their time and can make up to $180.

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 Kristin Fitch, B.A., at The Institute of Living in Hartford, CT at (860) 545-7574.

Are you frequently bothered by obsessive thoughts and compulsive behaviors?

Do you have obsessions and compulsions about checking, washing, cleaning, contamination, harming others, making mistakes, ordering things, and/or repeating actions?

The School of Social Work and The Center for Anxiety Related Disorders at Boston University are conducting a study which includes people with obsessive-compulsive disorder. Participants will receive $20 per hour. The study is open to adults 30 years of age or older who meet study criteria. For more information, please call The School of Social Work at Boston University at (617) 358-4213.

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

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

The selective serotonin reuptake inhibitors (SSRI) 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

(continued on page 14)

OCD NEWSLETTER

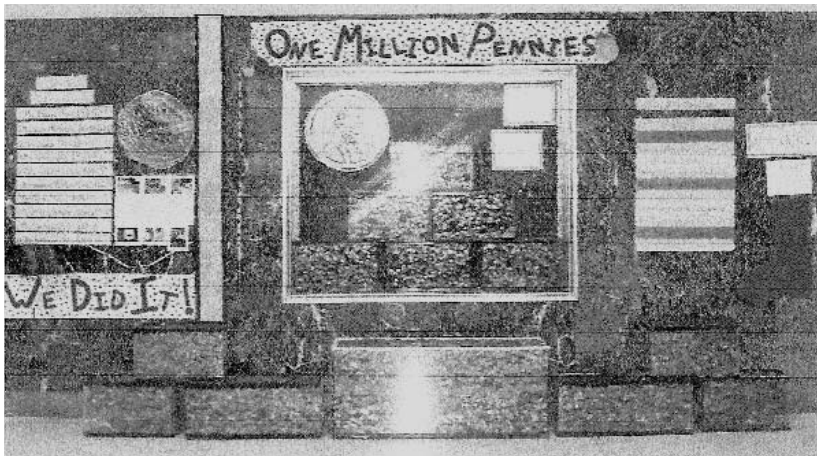
The OCD Newsletter is published six times a year.

Obsessive Compulsive Foundation, Inc.
Phone: (203) 401-2070
Fax: (203) 401-2076
Email: info@ocfoundation.org
Web site: www.ocfoundation.org
Joy Kant, President,
Board of Directors
Patricia B. Perkins, J.D.,
Executive Director/Newsletter Editor
Michael Jenike, M.D., Chairperson,
OCF Scientific Advisory Board

The Obsessive Compulsive Foundation (OCF) is a not-for-profit organization. Its mission is to increase research into, treatment for and understanding of Obsessive Compulsive Disorder (OCD). In addition to its bi-monthly newsletter, 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.

Pennies From Heaven, Actually From Central Boulevard School

On May 10, 2007, the students and teachers of Central Boulevard Elementary School in Bethpage, NY, assembled to celebrate their goal of collecting one million pennies during this school year. In August Deborah Deasy, a teacher in this school, realized that a guest author who wrote a book titled *What is a Million?* was coming to Central Boulevard School in May. She decided that the students needed to see what a million of something looked like. What better than one million pennies! It was decided that the money would be given to research foundations that work on illnesses that affect children. Soon after starting the project, seeing what one million pennies looked like became far less important than being able to help others with the money. The school actually collected $10,500 in six months. It was truly a school project. Two students from each of the classes that collected the most money made presentations of oversized checks to eleven foundations, each of whom sent representatives. Deborah chose all of the foundations, since she headed up the project and her class contributed $4,272 of the money collected. In speaking of her class at the assembly Deborah said, "Your hard work amazed me, your perseverance inspired me, but most of all your sense of caring touched me deeply." Being herself a member of the OC Foundation, Deborah put it at the top of the list to receive a donation from the school. Dr. Wendy Penzel, from the Western Suffolk Psychological Services, accepted the check of $1,000 in the name of the Obsessive Compulsive Foundation.



Mark's Ride

by Michelle Candoo

On a bright, sunny Saturday this past May, 85 people gathered at Marymoor Park in Redmond, Washington, to bike the Sammamish River Trail while raising more than $4,000 for the Obsessive Compulsive Foundation. The event, known as Mark's Ride, was planned by the friends and family of Mark Nelson as a way to remember the fun times they spent with him.

Mark's struggle with OCD began in his sophomore year of college. However, he looked forward to one day helping others with the disorder. Sadly, in 2005 Mark passed away before he was able to realize this dream. Through Mark's Ride, his friends and family have found a way to remember Mark, while at the same time championing his dream of helping those struggling with OCD.

From the time he was a small child, one of Mark's favorite activities was to ride his bicycle. At Mark's Ride, participants brought bicycles, strollers and in some cases, simply their walking shoes to enjoy the bike trail and a meal together in the park. Participants were asked to make a donation when they checked in. They wore T-Shirts proudly displaying Mark's artwork along with Bible verses which were important to him and his family.

Mark's Ride is an event Mark himself would have loved to be a part of with his family and friends coming together to enjoy the sport he loved, while raising money for the OC Foundation. Mark is truly missed but this event makes participants feel he is with them in spirit.

If you're interested in participating in the event in the future, please contact Michelle Candoo at MCandoo@gmail.com.

Chicago Affiliate Has New Name

The Obsessive Compulsive Foundation of Metropolitan Chicago (frequently abbreviated as "OCF Chicago") announces its new name:

OCD Chicago

To make it easier to find us in this age of electronic search and access, the Board of Directors decided that the Chicago affiliate will now operate under the name OCD Chicago. The new name – and an "extreme makeover" of our web site coming soon – are only two of the exciting changes due in 2007. More new publications and other focused support for people with OCD and their families will make 2007 a landmark year and the kick-start of enhanced outreach to our community.

This Article is Ra

Leslie Shapiro, LICSW
Ryan Boxill, Ph.D.
Behavior Therapists, OCD Institute
Belmont, MA

Based on our collective empirical experience treating OCD, especially scrupulosity and intrusive "bad thoughts," it has become clear that along with excessive anxiety, excessive guilt misguides sufferers into erroneously judging the "morality" of a situation and performing rituals that are intended to assuage the guilt. Paradoxically, the effort to prove "goodness" through rituals ends in emptiness and more suffering. They do not accomplish their intended purpose. This form of "humility" sacrifices genuineness and reinforces the OCD. Life becomes more and more rigid, more and more limited.

Not every OCD sufferer is driven by guilt via his or her symptoms, but most of the OCD subtypes on the Y-BOCS seem to lend themselves to this bind (aggressive/harming, contamination, sexual, religious, and superstitious obsessions). Obsessions are typically taboo in nature; thoughts people are not "supposed" to have. OCD sufferers experience a spike in anxiety and heightened physiological arousal when triggered, which is mistaken as evidence that something is wrong (in this case, morally). Sufferers can feel horrified about the content of their obsessions and the perceived consequences that others will be harmed by any lapse in their moral judgment or common sense.

Behavior, Emotion, Cognition and Biology

Rituals do not free the person from guilt. They only exacerbate it. Guilt often serves as the mechanism by which rituals, avoidance, and reassurance behaviors are reinforced and perpetuated. This erroneously validates that thoughts/ beliefs are accurate and deserve guilt-ridden reactions.

Unfortunately, this vicious cycle starts just like any other conditioned response. The individual experiences a thought and most importantly believes that it is wrong/bad, which in turn creates an emotion consistent with the belief. For example, if the person believes that his/her actions or thoughts are wrong, immoral or bad, then naturally he or she will experience an aversive emotion such as guilt.

Negative thoughts and beliefs can only create aversive emotions like guilt. If she or he believes s/he are responsible for having the negative thought, then s/he will naturally experience an aversive emotion such as anxiety, guilt, sadness, shame, etc. This aversive emotion will serve to make the irrational thought appear valid, appropriate, and intense.

Most lay people assume that "I feel guilty because I might be a bad person" or "I did something wrong." The reality is that the emotional response is a reaction to having given the thought some credence, no matter how ridiculous it is. More importantly, emotions tend not be indicators of fact but merely consequences of a belief system.

Emotions serve the primary purpose of reinforcing a thought, no matter how irrational that thought may be. In essence, emotions make the thoughts stronger and more intense. These more intense thoughts in turn create even more intense emotions, which dictate behavior. The behavior in turn reinforces the thought, which perpetuates the emotion. Then we have a vicious cycle of guilt: "Think bad, feel bad, do bad."

Many OCD sufferers may notice that they will perform rituals without even feeling anxious. The mere belief that one might have had an intense thought will trigger guilt and dysfunctional behavior. Sometimes normal behavior will trigger guilt and cause the individual to become so conditioned to guilt that even experiencing minute sensations or feelings will trigger guilt. Once this vicious cycle has started and has been reinforced, the original trigger or initiator of the guilt no longer needs to be present to ignite this firestorm of guilt. To break this pattern, the person will need to intervene at one part of the cycle (the thought, the belief about the thought, or behavior). Preferably, the intervention will occur behaviorally by delaying the urge to respond to the guilt or by extinguishing it all together. Cognitive therapy can also be helpful to challenge the belief system from which the unwarranted guilt originates.

Guilt is also shown to be a function of Executive Functioning in the pre-frontal cortex. Executive Function differentiates conflicting thoughts, determines good and bad, better and best, same and different, future consequences of current activities, working toward a defined goal, prediction of outcomes, expectations based on actions, and social "control" (the ability to suppress urges that, if not suppressed, could lead to socially unacceptable outcomes). Human abilities to feel guilt or remorse, and to interpret reality, lie in the prefrontal cortex. In *The Imp of the Mind*, Lee Baer cites Carey Savage's theory about the likelihood of acting on obsessive thoughts stating: "The very fact that they feel guilt and distress about having bad thoughts should reassure them that their orbital frontal cortex is doing its job."

Types of Guilt

According to Gilligan et al (1998), healthy guilt serves to let us know when we have truly wronged another or violated a personal standard. If we experience healthy guilt, we usually seek to rectify the wrong done to another by apologizing and trying to make up for it. Like healthy prayer, there is a beginning and an end that serves to provide comfort and closure. If this closure cannot be achieved or if we cannot rectify a violation of our personal code, we then forgive ourselves, learn from it, let it go, and move on.

Further along the guilt spectrum is subjective guilt. According to Gilligan, subjective guilt involves the feeling of having committed a sin, a crime, an evil, or an injustice. It has the feeling of obligation, the feeling of being dangerous or harmful to others, and the feeling of needing expiation and deserving punishment. This type of guilt leads the OCD sufferer into obsessing about situations in which there is no clear wrongdoing but that the presence of doubt makes it difficult to shrug off.

Next along the guilt severity spectrum is unhealthy guilt. According to Borysenko, unhealthy guilt entails fear and doubt created by guilt-driven behaviors as diverse as perfectionism, overachievement, lack of assertiveness, and "helper's disease," wherein we care for everyone but ourselves. It also creates anxiety and depression – conditions in which we think everything is our fault and believe that life is hopeless – are also symptoms of unhealthy guilt. She further states that unhealthy guilt causes life to become organized around the need to avoid fear rather than the desire to share love. Guilt creates a psychic optical illusion that causes faults and fears to stand out while pleasure and happiness recede into the background.

It is healthy not to want to cause hurt to another person (most people do not have this intention). The problem with OCD is that doubting thoughts provoke artificial concern about the negative thoughts, and anxiety about the respective false threat or risk. "Just in case" is the default response, which reinforces the OCD cycle of obsessions and compul-

TED G (FOR GUILT)

sions. Those who have intrusive "bad" thoughts (don't we all?), be they violent and/or sexual, feel guilty for having them. People with scruples do not want to commit sins, offend God, or act immorally. It is not enough to suffer the thoughts. The person feels compelled to prove s/he didn't mean to have the thoughts, attempt to protect those whom the thoughts are about, and/or avoid situations in which s/he anticipates the thoughts will be provoked. Life becomes limited and the actual "good" of the person is sacrificed to the "bad" OCD. And, ironically, relationships with those who are being "protected" by the rituals are hurt by the OCD.

In her book, *Guilt is the Teacher, Love is the Lesson*, Borysenko lists 21 expressions of unhealthy guilt:

1. I'm overcommitted.
2. I really know how to worry.
3. I'm a compulsive helper.
4. I'm always apologizing for myself.
5. I often wake up feeling anxious or have periods when I am anxious for days or weeks.
6. I'm always blaming myself.
7. I worry about what other people think of me.
8. I hate it when people are angry with me.
9. I'm not as good as people think I am. I just have everybody fooled.
10. I'm a doormat.
11. I never have any time for myself.
12. I worry that other people are better than I am.
13. "Must" and "should" are my favorite words.
14. I can't stand criticism.
15. I'm a perfectionist.
16. I worry about being selfish.
17. I hate to take any assistance or ask for help.
18. I can't take compliments.
19. I sometimes worry that I am being – or will be – punished for my sins.
20. I worry about my body a lot.
21. I can't say no.

State-Anxiety/Guilt v. Trait-Anxiety/Guilt

State refers to transitory reactive anxiety and guilty in situations, while trait is more "hard-wired" and consistent. State-anxiety seems to involve heightened perceptual and physiological tension in which there is an overestimation of threat or risk. State-guilt results in an excessive sense of personal responsibility in situations where there is none. Trait-anxiety involves a proneness to a heightened chronic state of anxiety that the person brings to his/her general experiences in the world. Trait-guilt is an internalized sense of blame just for being alive.

In an experiment conducted by Gangemi, Mancini, and van den Hout (2007), it was found that people in "high-trait guilt had higher ratings of risk compared to low-trait participants." As with state-anxiety, they found that those with state-guilt interpret guilty feelings as an indication that they are in a situation that requires them to respond accordingly.

Thought-Action Fusion

The importance of the thought domain of cognition in OCD (Thordarson and Shafran, 2003) refers to beliefs and interpretations that negative intrusive thoughts and the feared consequences of having negative intrusive thoughts signifies something about oneself, that having negative intrusive thoughts increases the risk of bad things happening (such as, a harming obsessions could come true unless a prayer is said to protect the "victim"), and that they must be important because they occurred. The importance of the belief that one should have control of one's thoughts reinforces the guilt as the thoughts are held as evidence that the thinking is bad and there is a risk of causing harm.

Within the domain of importance of thought is the cognitive construct of thought-action fusion (TAF). According to Berle and Starcevic (2005), there are 2 styles of TAF. "Moral" TAF is the belief that unacceptable thoughts are morally equivalent to overt unacceptable actions. "Likelihood" involves the belief that thinking about an unacceptable or disturbing event makes the event more likely to occur in reality and that rituals must be performed to prevent it. Thus, one believes that thoughts are important because they are morally unacceptable and because they increase the risk of real life negative events.

The person with OCD has an intrusive bad thought (such as "I hope that person dies"). The person believes s/he is bad because s/he may have learned that having a bad thought is equal to acting on it. The individual may think or feel that perhaps s/he really meant the thought and, therefore, will be destined to hell, live in a state of sin, or have bad karma until this is resolved by an undoing ritual. This is the bind perpetuated by excessive guilt. Until s/he is willing to be courageous in the face of his/her unintended, unwanted, anxiety-provoking thoughts, s/he will be a slave to the vicious OCD cycle.

Individuals who believe their thoughts have increased the likelihood of a negative event occurring to someone else will often also form conclusions about their own morality for having thought something that could be harmful to others. Take the example of a woman who had an intrusive thought about her dad having a heart attack and consequently believes she is obligated to address the unwanted thought until she feels convinced she has done enough to protect him. Reacting to the thought with rituals does not translate into effectively controlling reality. She will never perform enough rituals to achieve that "just right" feeling to put it to rest. Ending the guilt, anxiety, and discomfort becomes the goal. The more effort she makes toward that end, the worse she actually feels, the more her OCD is reinforced, and, in turn, the more likely that the situation will negatively effect her interactions with her dad.

Of course, no one wants catastrophic events to occur; but most of us believe that we do not possess the power to make them happen by thinking them, that unthinking the thought, if that were somehow possible, could prevent it, or that we believe we are responsible for these thing happening when they do occur. In some ways, OCD is a very self-centered problem because the sufferer believes there is a direct causal relationship between his/her thought and reality.

Compulsive Apologizing and People Pleasing

A hallmark of obsessive guilt is compulsive apologizing. How can one person be responsible for so much wrong-doing that s/he expresses being sorry for every move s/he makes? There are many ironies to OCD. In this case, humility is the flip side of the deadly sin of pride. Apologies become meaningless when they are given compulsively. When a person expresses them for all situations, the apologizer appears not to be able to discriminate between imagined and serious wrong-doing. The receivers of these apologies dismiss them and may not take a meaningful apology seriously. It is not a gesture made from strength or healthiness.

People-pleasing is another indicator of excessive guilt. Putting others' needs ahead of our own is not an act of selflessness but self-preservation. Instead of acting out of altruism, the ulterior motive is avoiding conflict, wanting to be liked (i.e., not hated and retaliated against), avoiding one's own negative emotions (focusing on others as a distraction),

(continued on page 8)

Research Di

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

OCD seldom occurs by itself. Most sufferers also experience symptoms and signs of one or more additional psychiatric disorders. Depression is very common, occurring in up to two-thirds of OCD patients at sometime in their lives. The articles reviewed here describe other disorders that can occur with OCD (comorbidity = sicknesses together). Comorbid disorders complicate treatment of OCD, but once recognized they can be managed properly so that the OCD can be treated as effectively as possible.

Treating comorbid presentations: obsessive-compulsive disorder, anxiety disorders, and depression

D.R. Ledley, A. Pai and M.E. Franklin. In: Antony MM et al. (eds), Psychological Treatment of Obsessive-Compulsive Disorder: Fundamentals and Beyond, American Psychological Association: Washington, DC, 281-293, 2007

Panic disorder, social anxiety disorder, posttraumatic stress disorder (PTSD), generalized anxiety disorder, phobias and depression all have symptoms that overlap with OCD symptoms. It can be difficult to decide if an individual has a single diagnosis of OCD or an additional diagnosis of one of these disorders. Guidelines are provided for differentiating OCD from other anxiety disorders and depression. Authors review comorbidity rates and impact of comorbid disorders on treatment outcome. Usually, comorbid anxiety disorders and depression do not interfere greatly with OCD treatment. However, when severe depression or anxiety disorders interfere substantially with OCD treatment, these other disorders may need to be treated first. Specific examples are given, such as the fear of having a panic attack preventing a patient from leaving home or severe social anxiety preventing a patient from participating in group therapy. In cases of comorbid PTSD and OCD, the disorder causing the most distress may be treated first, although OCD and PTSD both respond to potent serotonin reuptake inhibitors (SRIs) and cognitive behavior therapy (CBT). For depressed patients with suicidal thoughts, treatment of depression is foremost. Even minimal depression can cause difficulties, such as affecting a patient's motivation for treatment and ability to carry through with homework assignments. Authors conclude that with slight modifications to treatment for comorbid problems, interference can be minimized and often by the end of treatment these other problems will also be significantly improved.

An investigation of traumatic life events and obsessive-compulsive disorder

Behaviour Research and Therapy, 45:1683-1691, 2007, K.R. Cromer, N.B. Schmidt and D.L. Murphy

In OCD, trauma and stressful life events may be factors in the onset and course of illness. This study examined relationship(s) between traumatic life events (TLEs) and OCD in 265 adults admitted to the OCD Clinic at the National Institute of Mental Health. Of these individuals, 54% reported having experienced at least one TLE in their lifetime. The presence of one or more TLEs was associated with increased OCD symptom severity. This relationship remained significant despite controlling for key variables including age and depression. In addition, checking and ordering compulsions were two symptoms more likely to be associated with the occurrence of TLEs. Researchers discussed the possibility that individuals with greater OCD severity may be more sensitive to recalling TLEs. While this study properly calls attention to the possibility of TLEs in those suffering OCD, it also reminds us that for half of those with OCD, no traumatic life event was found.

Trauma and posttraumatic stress disorder in treatment-resistant obsessive-compulsive disorder

Depression and Anxiety, Epub ahead of print, 2007, B.S. Gershuny, L. Baer, H. Parker et al.

This is another study looking at the relationship between OCD and trauma or posttraumatic stress disorder (PTSD). Participants included 104 individuals with OCD who sought treatment from the Massachusetts General Hospital OCD Clinic. All individuals were labeled "treatment-resistant" due to failure of earlier treatment attempts. Differing from the previous study, an even greater number of individuals (82%) reported a history of at least one trauma and 39.4% of the individuals met criteria for current PTSD diagnosis. Interpersonal traumas and a greater number of traumas experienced were most predictive of the severity of the PTSD. Also, individuals with OCD and comorbid depressive disorder or borderline personality disorder appeared at particular risk for a comorbid PTSD diagnosis. In conclusion, PTSD was relatively common in individuals diagnosed with treatment-resistant OCD. The question remains whether a history of trauma and untreated PTSD may lead to the development of treatment-resistant OCD or whether the symptoms of OCD cause someone to be more vulnerable to developing PTSD after experiencing a trauma. Researchers recommend further research on the relationship between OCD and PTSD.

Do personality disorders predict negative treatment outcome in obsessive-compulsive disorders? A prospective 6-month follow-up study

European Psychiatry, 21:319-324, 2006, S. Fricke, S. Moritz, B. Andresen et al.

There have been reports that comorbid personality disorders negatively impact the treatment of OCD. In particular, schizotypal personality disorder has been considered a risk factor for treatment failure. Schizotypal traits include excessive social anxiety, odd beliefs or magical thinking, fewer close friends, odd speech, and suspiciousness. In this study, 24 of 55 OCD individuals (44%) had a comorbid personality disorder. Treatment consisted of cognitive-behavior therapy (CBT), with or without SRI medication. In comparison to patients without personality disorders, these patients benefited equally from treatment. However, there was a tendency for patients with higher scores on schizotypal traits, as well as on passive-aggressive traits, to improve less at post-treatment. Results suggest that CBT works for OCD even for those with personality disorders, with the possible exception of schizotypal and passive-aggressive personality disorders.

OCD with comorbid OCPD: A subtype of OCD?

Journal of Psychiatric Research, Epub ahead of print, 2007, M.E. Coles, A. Pinto, M.C. Mancebo et al.

Obsessive compulsive personality disorder (OCPD) is characterized by excessive preoccupation with orderliness and perfectionism. OCPD and OCD are separate disorders that share some of the same symptoms. Over one-fourth of 238 OCD patients in this study were diagnosed with comorbid OCPD. These 65 individuals with both OCD and OCPD were com-

gest

pared to the 173 individuals with OCD alone. The OCD + OCPD subjects had a significantly younger age at onset of first OCD symptoms. The OCD + OCPD subjects also had a greater frequency of symmetry and hoarding obsessions, and cleaning, ordering, repeating, and hoarding compulsions. Also, subjects with OCD + OCPD had higher rates of comorbid anxiety disorders and avoidant personality disorder. The OCD + OCPD subjects also had significantly poorer global and social functioning, despite similar overall severity of OCD symptoms. Findings indicated that individuals with both OCD and OCPD had distinct clinical characteristics. Researchers suggest that OCD associated with OCPD may represent a specific subtype of OCD.

Treatment responses of inpatient eating disorder women with and without co-occurring obsessive-compulsive disorder

Eating Disorders, 15:111-124, 2007, E.J. Cumella, Z. Kally and A.D. Wall

Eating disorder (ED) and OCD are often comorbid. In this study of 2,971 hospitalized women with eating disorders, 656 (22%) were also diagnosed with OCD. A comparison was made between women with and without comorbid OCD. ED patients with both disorders were more ill at hospital admission and had developed the eating disorder at an earlier age than those patients without OCD. Compared to ED patients without OCD, more with OCD were diagnosed with anorexia nervosa and fewer with bulimia nervosa. Interesting and important, patients with and without OCD obtained the same degree of improvement in ED symptoms and behaviors, both at discharge and at a one-year follow-up. Thus, the comorbid OCD did not impact the ED treatment responses.

Tics moderate treatment outcome with sertraline but not cognitive-behavior therapy in pediatric obsessive-compulsive disorder

Biological Psychiatry, 61:344-347, 2007, J.S. March, M.E. Franklin, H. Leonard et al.

The presence of a comorbid tic disorder is often listed with factors predicting poorer outcome in treatment of children and adolescents with OCD. Using data from the Pediatric OCD Treatment Study (POTS), researchers looked at whether the presence of a comorbid tic disorder influenced response after 12 weeks of treatment with cognitive-behavior therapy (CBT), medication treatment with sertraline (Zoloft), combination of CBT and sertraline or in the control group taking a pill placebo. In this study, 15% (17 of 112) patients were diagnosed with a comorbid tic disorder. Tic disorders did not adversely affect response to CBT alone or CBT plus medication. However, tic disorders appeared to adversely affect treatment with medication alone. Patients with tic disorders did not respond any better to sertraline alone than to pill placebo. Researchers recommend that children and adolescents with OCD and comorbid tic disorder should begin treatment with CBT alone or the combination of CBT with a serotonin reuptake inhibitor (SRI).

Effect of comorbid tics on a clinically meaningful response to 8-week open-label trial of fluoxetine in obsessive compulsive disorder

Journal of Psychiatric Research, 41:332-337, 2007, D.S. Husted, N.A. Shapira, T.K. Murphy et al.

This study also evaluated the effect of comorbid tic disorder on treatment response. Here, 74 adult patients (13 with comorbid tics and 61 without tics) were treated for 8 weeks with fluoxetine (Prozac), up to 40 mg/day. In contrast to the study above, patients with and without tic disorders responded with similar levels of improvement to serotonin reuptake inhibitor (SRI) medication. For OCD patients with tics, many clinicians begin treatment with a combination of SRIs and antipsychotic medications. The assumption is patients with comorbid tic disorders will not respond adequately to SRI monotherapy and will need augmentation treatment. This study contradicts this belief, demonstrating that presence of tics did not inhibit response to fluoxetine monotherapy. Antipsychotic medications can be effective treatment for tics; however, their use is not recommended unless tics cause significant distress. If patients with comorbid tic disorders can be effectively treated with SRI medication alone, then patients can avoid side effects of antipsychotic medications. Interestingly, there was a decrease in tic severity with fluoxetine treatment. Researchers speculated that if anxiety can worsen tic severity, then treatment of anxiety could lessen tic severity. What this study fails to tell us is whether placebo might have generated equal improvement as medication and CBT greater improvement than medication, as was found in the March et al. study above. Another conclusion from these studies is that open-label research, while easier to conduct, is less valuable than placebo-controlled studies.

Bipolar and nonbipolar obsessive-compulsive disorder: a clinical exploration

Comprehensive Psychiatry, 48:245-251, 2007, A. Zutshi, P. Kamath and Y.C.J. Reddy

Researchers from the National Institute of Mental Health in Bangalore, India, compared 28 patients with OCD plus bipolar disorder (bipolar OCD) to 78 patients with OCD without bipolar disorder (nonbipolar OCD). The course of OCD varied between groups. The majority of bipolar OCD patients had an episodic course—clear evidence of remission where symptoms either disappeared or were only minimal. The majority of nonbipolar OCD patients had a chronic course—OCD symptoms persisted for most of the course. Most bipolar OCD patients reported worsening of OCD in depression and improvement of OCD in manic or hypomanic episodes. Bipolar OCD patients had a greater family history for affective disorders (and not for OCD). Bipolar OCD patients had less severe OC symptoms and higher rates of other anxiety disorders. Findings indicated that bipolar OCD differs substantially from nonbipolar OCD in several aspects.

*The Madison Institute of Medication publishes information booklets. Authored by experts on each disorder, these guides offer information about various psychiatric disorders and address questions most frequently asked by patients and their families. Booklets may be ordered online at **www.miminc.org** or by calling our Information Centers at 608-827-2470. Available booklets on disorders discussed in this Research Digest are:

Depression and Antidepressants: A Guide, 2005

Obsessive Compulsive Disorder: A Guide, 2000

Obsessive Compulsive Disorder in Children and Adolescents: A Guide, 2002

Panic Disorder and Agoraphobia: A Guide, 2004

Posttraumatic Stress Disorder: A Guide, 2007 New Revised Edition

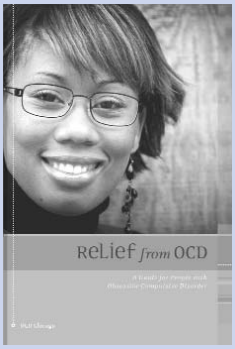
Social Anxiety Disorder: A Guide, 2000

The Institute also publishes information booklets on specific medications, including bipolar disorder medications (Lithium and Bipolar Disorder: A Guide; Divalproex and Bipolar Disorder: A Guide; Carbamazepine and Bipolar Disorder: A Guide; Oxcarbamazepine and Bipolar Disorder: A Guide).

Relief From OCD: New Guide Available Free From OCD Chicago

Relief from OCD: A Guide for People with Obsessive Compulsive Disorder is a comprehensive 36-page publication about OCD and the effective forms of treatment that are currently available – treatment that has already enabled thousands of people with OCD to learn to manage symptoms of the disorder and live happy and productive lives.

The guide provides information about the symptoms of OCD, myths and facts about the disorder, related conditions such as major depression and attention deficit disorder, and how OCD affects the family, work, and school. It also discusses the value of support groups, and responds to many frequently asked questions.



"No other such free publication exists," explained Ellen Sawyer, Executive Director of OCD Chicago. "This publication fills a void: it's reassuring, accessible, and very readable, and at the same time it contains a lot of detail to help people with OCD get started on a treatment program. We wanted to gather the best available information together in one place and to present it in a form that empowers people to take action. It's a roadmap to finding relief from OCD."

Marty Silverman, President of OCD Chicago, describes the guide as practical and pragmatic. "It presents a practical way of thinking about the problem of living with OCD by using proven treatment methods that teach people to cope with their symptoms. Obsessive Compulsive Disorder is a chronic condition; but with the right type of treatment, people with OCD can learn to cope very effectively and lead wonderfully rich lives. While scientists have not yet found a 'cure' for OCD – and that may take years – treatment is available now and it's lightning fast by comparison."

Relief from OCD is available as a PDF download at the OCD Chicago web site, www.ocdchicago.org. Individuals who are unable to download or who do not have a computer can write for a free copy by sending their full mailing address and the name of the publication to OCD Chicago, 2300 Lincoln Park West, Chicago, IL 60614, or by emailing to info@ocdchicago.org.

The publication was made possible by a contribution from the William Blair Foundation.

Rated G (for guilt)

(continued from page 5)

avoiding negative judgment by others (saying what I think people want to hear, not what I think, keeps me safe), problems with decision-making (if I commit to a decision, then I have to take responsibility for it), avoiding mistakes (if I behave perfectly I won't call negative attention to myself), and so on.

PSYCHOSOCIAL TREATMENTS

Exposure and Response Prevention

Exposure and response prevention (ERP) is the first line and most straight-forward treatment of obsessive doubt and anxiety. In exposure work, people typically habituate to the actual trigger and can prevent themselves from having to ritualize to neutralize the anxiety. In some cases, however, generalization to related situations does not seem to naturally flow from the habituation process. People seem to be able to reconcile treating a particular obsession because it has been "sanctioned" in treatment sessions, but have difficulty implementing the same ERP strategies across laterally triggering situations. Sessions end up providing tacit reassurance.

When treatment plateaus because the fear hierarchy items have been addressed and situational anxiety has improved through ERP, treaters and patients alike may decide that this is the time to titrate behavior therapy sessions in order for the person to maintain his/her gains more autonomously. From clinical experience in working with people at this stage of treatment and recovery, it seems that high trait-guilt can lead to relapse because it is not always apparent during active ERP treatment.

Cognitive Therapy

The challenge in cognitive therapy is to dispel the faulty core belief that "I am inadequate and unworthy." It also involves breaking the relationship between TAF and obsessions, and helping people disrupt their association to an obsession by not responding to it just because it is triggered. Having the thought does not mean the thought is wanted. And, just because the thought occurred does not mean anything in reality actually happened. The thought occurs because of the OCD, and what matters most is one's response to it, which ideally is nothing.

Assertiveness Training

Assertiveness is the antidote to guilt and low self-esteem. We have experience teaching assertiveness skills to people with OCD, social anxiety, and panic disorder. The people with whom we work may never have learned assertiveness skills because of their proclivity toward anxiety and fear. They may never have had assertive role models to emulate. Assertiveness is practicing one's personal rights, responsibilities, and self-care. It is not a burden to others. On the contrary, assertiveness commands respect and trust from others because they know where you stand or how you feel about an issue. Assertiveness manages stress by addressing a problem situation in the moment. Stress is alleviated by honestly and effectively communicating about yourself. It enables letting go of anger and resentment so that these feelings do not boil up and are not expressed inappropriately.

Passivity is the typical end of the spectrum for the guilty. People who feel "guilty" don't feel they have rights or power. Aggression is the other end. People fear they will "lose it" and be out of control. Assertiveness is neither of these. Here are 11 basic assertive rights from *The Assertiveness Option*

1. The right to act in ways that promote your dignity and self-respect as long as others' rights are not violated in the process
2. The right to be treated with respect
3. The right to say no and not feel guilty
4. The right to experience and express your feelings
5. The right to take time to slow down and think
6. The right to change your mind
7. The right to ask for what you want
8. The right to do less than you are humanly capable of doing
9. The right to ask for information
10. The right to make mistakes
11. The right to feel good about yourself

Humor

With all that has been said about OCD, we know that taking it seriously allows it to be in control. A reliable sign of getting to recovery is a sufferer who is able to express humor in treatment. Using a sense of humor is another antidote to obsessive fear because laughter in the moment disarms the fear and puts it in its proper place. There is no productive reason to take the obsessions seriously since they are lies that the OCD tries to trick people into believing.

In closing, we would like to make this recommendation: Guilt – let it go and live your life!

All communication about this article should be addressed to: shapiro@ocd.mclean.org.

Alexian Brothers Behavioral Health Hospital

In the following interview, Dr. Patrick B. McGrath, Ph.D., Director of the OCD and Related Anxiety Disorders Program at Alexian Brothers Behavioral Health Hospital in Hoffman Estates, Illinois, will talk about a new treatment program available in the Chicago area for OCD.

Newsletter: We have learned that Alexian Brothers Behavioral Health Hospital (ABBHH) has opened an intensive treatment program for OCD. Can you please describe the program to us?

Dr. McGrath: The OCD and Related Anxiety Disorders Program (OCDRADP) is an outpatient program with two levels of care. The Partial Hospital Program (PHP) is a six hour a day, five day a week program and the Intensive Outpatient Program (IOP) is a three hour a day, four day a week program. The main focus of these programs is the intense treatment of OCD and other anxiety disorders using Cognitive-Behavioral Therapy (CBT) and Exposure and Response Prevention (ERP). The day is structured in such a way as to allow patients to do both ERP and CBT on a daily basis. Patients in the PHP will also meet weekly with a psychiatrist to assist with any medication management concerns that they may have.

Patrick B. McGrath, Ph.D.

Newsletter: What types of disorders will you be treating at OCDRADP?

Dr. McGrath: We will be treating all anxiety disorders: OCD, Generalized Anxiety Disorder, PTSD, Specific Phobias, Panic Disorder, and Social Phobia.

Newsletter: What are the ages of people that you see?

Dr. McGrath: We are currently working with adolescents and adults. Our typical range of ages is between 13 to 60, though we will take patients that are older than that; and we can also consult with our child program if any children are showing any OCD symptoms.

Newsletter: Is your program covered by insurance?

Dr. McGrath: We are covered by most insurance programs as well as Medicare and Medicaid for certain populations. One advantage of being at a hospital is that we have an excellent billing department who will be of great assistance in helping new patients figure out their coverage levels as well as assist on any precertification needs. Our billing department will also let you know about your co-pay or deductible requirements and meet with you weekly to review your account with you.

Newsletter: How long are patients typically in the program?

Dr. McGrath: Patients are typically in the PHP for two weeks, and then typically step down into the IOP for two weeks. As the patients progress in the program, we will work on transitioning them into traditional outpatient therapy with either their referring therapist or with a therapist who specializes in OCD. There is no time limit on the program as long as patients are progressing.

Newsletter: Are families ever involved in treatment?

Dr. McGrath: Yes they are. We try to do family sessions on a weekly to bi-weekly basis, as long as the patients are willing. If they are not, we do try to encourage them to do a family session, though we never make anyone do them.

Newsletter: What would you consider to be a typical patient?

Dr McGrath: Our typical patients all have primary diagnoses of OCD or other anxiety disorders. Most of our patients have attempted traditional outpatient therapy and have needed to step up to a higher level of care, or they are referred to us from an inpatient or residential setting. Many of our patients have also transferred to our program from other programs in the hospital. Many of these patients start with some cross-tracking with us while they are in the other program, and then transfer to us when the issues that they have been dealing with in the other program have been successfully treated. For example, someone may enter our Chemical Dependency (CD) Program to be weaned off of benzodiazepines that they were using to deal with their OCD; and then once they start to stabilize, they can cross-track with us for an hour a day. When they complete the CD program, they can then come to the OCDRADP to specifically address their OCD.

Newsletter: How many patients do you treat in the program at any time?

Dr. McGrath: Our staffing numbers are designed to adjust to the number of patients that we have in the program. Therefore, we have the luxury of treating as many patients as we have trained staff. As our numbers grow and we train even more staff, we will continue to be able to serve a wide variety of patients.

Newsletter: What is your training in treating OCD? Who do you have on your staff?

Dr. McGrath: I am at the program every day and do see patients in the program on a daily basis, barring any visits to conferences or speaking engagements. I try to work with all of the patients during their stay in the program, and will have a hand in all of their treatments through staffings and supervision of my team.

My specific training in OCD started in 1999 under the supervision of Dr. Alec Pollard at the Saint Louis Behavioral Medicine Institute as a postdoctoral fellow. After my two year fellowship, I joined the staff at SLBMI for several months; and then went to Michigan State University, where I led the Anxiety Disorder and Eating Disorder group therapy program, as well as the Cognitive Behavioral Therapy seminars. I then came to the Chicago area and opened an anxiety treatment center at a hospital in the western suburbs and moved that program to ABBHH in the winter of 2006.

In addition to me, we have two full-time therapists, Adrienne Ahlquist, L.C.S.W., and Shayla Parker, L.C.P.C., both of whom have trained under and worked for me for three years. We also have students who are working on their doctoral degrees who do rotations with us as well, and we hope to be able to offer an internship position in the next year or two.

Newsletter: What other services do you offer at ABBHH?

Dr. McGrath: ABBHH is a full service behavioral health hospital. We have inpatient units for children, adolescents, adults, and geriatric patients. We have many specialty programs as well, including Self Injury Recovery Services, Eating Disorders, and Chemical Dependency, in addition to general mental health services for children, adolescents, adults, and older adults.

If a patient with OCD comes into our program and needs help in other areas, we can usually offer them ancillary services. We can also hospitalize patients for inpatient stays if it required.

Newsletter: What do patients do after completing the program?

Dr. McGrath: We refer the patient back to the therapist that referred him/her to the program. However, there are times that the patients want to continue to work with an OCD specialist. In these cases, we have some availability to see them on an outpatient basis, or we can refer them to some therapists in the area that work specifically with OCD.

Newsletter: If people were to come from outside of the Chicago area for treatment, do you have facilities where they may stay?

Dr. McGrath: We do have relationships with some of the hotels in the area where we get special rates. We welcome individuals to come to our facility if there are not facilities available in their area.

Newsletter: How can someone get in touch with you about your programs?

Dr. McGrath: Please feel free to contact me directly at:
Alexian Brothers Behavioral Health Hospital
1650 Moon Lake Boulevard
Hoffman Estates, IL. 60169
Phone: (847) 755-8531
Pager: (847) 479-0732
Fax: (847) 755-8508
patrick.mcgrath@abbhh.net.

Message From the President

(continued from page 1)

long periods of time, the student who handed in his assignments late with small holes in the paper due to continuous erasing, or the bright student who took longer than was expected to complete a reading assignment.

It is the OCF's hope that we can make these students' lives easier in the future. We owe it to students in the classroom everywhere who struggle with OCD to be identified and supported. By educating teachers about the disorder and by providing information as to how they can make accommodations in the classroom, those suffering with OCD will be more comfortable in their academic and everyday lives.

An example of this recent effort to extend OCD awareness in the school system is taking place in my hometown of Newton, Massachusetts. One dedicated high school counselor, Lenny Libenzon, began developing a series of mental health programs to be attended by students, parents and teachers. In doing so, he has requested our Public Service Announcement posters and the "OCD in the Classroom" kit. Lenny has also extended an invitation to Newton's other public high school. If you are interested in following in this counselor's footsteps, please contact an OCF staff member or a member of the board.

In addition to educating the public, the OCF is committed to raising money for research. This year we awarded over $290,000 to the following researchers from around the country:

Jamie Feusner, M.D., Department of Psychiatry and Biobehavioral Sciences, David Geffen School of Medicine, UCLA, Los Angeles, CA "Visual Information Processing in Body Dysmorphic Disorder";

John Piacentini, Ph.D., ABPP, Division of Child and Adolescent Psychiatry, Semel Institute for Neuroscience and Human Behavior, UCLA, Los Angeles, CA "Controlled Evaluation of Positive Family Interaction Therapy (P-FIT) for Children and Adolescents with OCD";

Rene Staskal, Department of Counseling, Clinical and School Psychology, University of California at Santa Barbara, Santa Barbara, CA "Cross–Cultural Issues in Assessment and Identification of Obsessive Compulsive Disorder in the Public School Setting";

Golda Ginsburg, Ph.D., Division of Child and Adolescent Psychiatry, Johns Hopkins University School of Medicine, Baltimore, MD "Psychosocial Treatment of Obsessive Compulsive Disorder in Young Children";

Arthur A. Simen, M.D., Ph.D., Department of Psychiatry, Yale School of Medicine, New Haven, CT "Genomic Copy Number Variation in Obsessive Compulsive Disorder";

Kiara R. Cromer, M.S., Department of Psychology, Florida State University, Tallahassee, FL "A Prevention Program for Postpartum OC Symptoms";

Jordana R. Muroff, M.S.W., Ph.D., Boston University School of Social Work, Boston, MA "Delivery of Internet Treatment for Compulsive Hoarding (D.I.T.C.H.)";

Jonathan Abramowitz, Ph.D., Department of Psychology, University of North Carolina at Chapel Hill, Chapel Hill, NC; "Enhanced Cognitive Behavior Therapy for OCD: A Couple-Based Approach (2 year study)."

I want to thank Dr. Sabine Wilhelm and her committee for the long hours that they put in selecting these recipients. Congratulations to this year's award winners.

Joy Kant
President of the Board of Directors of the Obsessive Compulsive Foundation

Homebased Treatment

(continued from page 1)

results in better exposure and response prevention (ERP) planning; and, thus, greater compliance with the plan.

Unlike what takes place in most office based behavior therapy, in HCBT patients receive behavioral coaching during ERP in the environment in which their symptoms naturally occur. For example, someone engaging in ERP for fear of causing harm obsessions may be coached while walking through a busy subway station without engaging in checking rituals.

Many patients who have failed outpatient trials of behavior therapy have reported that ERP assignments were too difficult to perform on their own and that therapist-guided ERP was helpful. In my clinical experience, this assistance increases motivation for treatment, the likelihood for habituation, compliance with homework assignments and helps to ensure appropriate application of cognitive interventions. Once a patient has habituated to an item on the hierarchy and is able to perform self-directed ERP for homework, the coaching is faded and HCBT focuses on the next item on the hierarchy.

HCBT provides an excellent opportunity to consistently include family or other significant people in the patients' treatment, which is often unrealistic in traditional outpatient settings. Often times in my practice, family members are included in a part of most therapy sessions in order to learn about OCD, ERP, how to become an effective behavioral coach, how to manage reassurance-seeking questions and/or other family involvement in rituals and how to manage expressed emotion in relationships. In my experience, this level of family involvement is essential and increases treatment compliance and relapse prevention, especially for children and adolescents, because OCD symptoms tend to stress everyone in the family system, not just the patient.

HCBT sessions, consisting of 90-120 minute appointments one to two times per week, are generally longer than most outpatient behavior therapy sessions in order to provide enough time for behavioral planning, skills training, *in vivo* ERP and family meetings. As patients master items on their hierarchy and manage gains independently, treatment is faded and frequency and duration of sessions decrease. For example, a patient I am presently treating, has recently transitioned from an intensive treatment setting. Initially, we met three times a week for 90 minutes to work on skills training, family psycho-education and *in vivo* ERP. He has successfully habituated to all items on his hierarchy and we are now meeting one time a week for 60 minutes to work on relapse prevention.

While I believe that HCBT is an effective way to treat OCD symptoms, especially for patients who have failed trials of traditional outpatient behavior therapy, there are several obstacles to providing HCBT. Because HCBT is different from traditional outpatient behavior therapy in many ways, it has been difficult for some patients to get their insurance companies to cover this treatment. Very recently, I have found that insurance companies are reimbursing this therapy if it is billed as an extended outpatient session. Also, many employers now offer their employees flexible healthcare benefits, and patients are being reimbursed for HCBT treatment sessions through these accounts if their PCP writes a letter stating that the therapy is medically necessary. Another obstacle to providing HCBT is the travel time to the patient's house. I usually confine my travel time to 20-30 minutes and schedule patients who live close to each other on the same day.

The number of therapists offering HCBT has increased since I was trained by Dr. Steven Willis during my graduate school internship at McLean Hospital in 1996, but there are still very few trained professionals providing this level of care to people with OCD. I encourage OCD specialists to consider this treatment option for patients in their practices, despite the obstacles.

Denise Egan Stack is affiliated with the McLean OCD Institute and has a private practice in Boston, MA.

Self-Directed Treatment

(continued from page 1)

It is important that you understand how the exposure, ritual prevention, and awareness (ERPA) exercises are related to the way the symptoms work. So let's review the series of events that takes place during a cycle of OCD symptoms, commonly called an OCD spike. First, there's a trigger, something that is noticed in your physical, social or mental worlds. Second, it instantly activates an obsession – thoughts, feelings or impulses that are distressful. Almost simultaneously, you feel fear, guilt, apprehension, dread, anger or any number and combination of distressing emotions. These three events – exposure to a trigger, activation of an obsession, and feelings of distress – are sensed as happening together, as a single event. Therefore, the terms, "trigger," "obsession," and "distress" are used interchangeably to refer to this seemingly single event – the spike. Your natural reaction is to turn it off as quickly as possible. Finally, by trial and error, you find out that by repeating certain actions and/or mental gyrations you get temporary relief until the next obsession hits.

ERPA exercises address each one of these events. First, you select a trigger for a particular obsession-compulsion combination and then practice exposure to this trigger. During the exposure, the next step is to refrain from rituals and instead practice awareness of the distress. When this is successfully done the distress fades away. Because the obsession that used to cause terrible anxiety no longer has that power, it becomes insignificant, making it intrusive and repetitive no more. With the absence of the obsessions, there is no need for compulsions. The exercises have changed the brain, which in turn changes behaviors and emotions. Desensitization has occurred. The exposure exercise is the vehicle, the Rolls Royce of treatments, which delivers this result.

By practicing the exercises at least one to two hours per day (including weekends and holidays), you should made good progress. When this schedule is adhered to, most people desensitize themselves to the particular trigger they're working on within five to seven days. This success gives them a big dose of confidence that they can control their anxiety, and increases their motivation to pursue and eradicate it. They now truly believe they will become "scared fearless."

To put together an exposure exercise, you'll be following these steps:

1. Select a trigger, an obsession-compulsion combination for elimination.

2. Practice exposure: by bringing on the obsession in reality and in imagination.

3. Practice ritual prevention by refraining from doing compulsions and fear blocking behaviors.

4. Practice acceptance fully experiencing the triggered thoughts, images, impulses, emotions and physical sensations they set off.

I'll explain each of the above activities as follows.

Selecting an Obsession-Compulsion Combination for Elimination

The best obsessions-compulsion combination to target is usually the obsession-compulsion combination that is the least distressful. Even though you may be eager to get rid of the most troublesome of your symptoms, it's best to start with the one that provides the greatest chance for success. After all, nothing succeeds like success. Don't worry; we will eventually deal with all of your triggers. As you are aware, there will be some stress associated with the exercises you are about to undertake. So start with the easiest one first to keep the distress at a minimum.

Exposure: Bringing on the Obsessions

The exposures involve making contact with triggers for obsessions in reality, which are in the outer physical and social world, or in imaginary situations, which are in the inner mental world because fear is the problem and fear is the solution. I realize that the idea of facing fear is quite scary, but it's necessary. In case after case, patients have reported that once they start confronting fear, they find it not to be nearly as distressful as anticipated. More importantly, they discover that exposure works. The obsessions stop triggering fear and become just "thoughts." Being neutral with no emotional impact, they are insignificant and gradually fade away.

Shaping

Keep in mind that the exposure exercises are done in a most gradual way, moving toward a goal slowly. This gradual way of making progress is called shaping. Start with a situation that causes only minimal distress and stay with it until you have little or no reaction to it. Only then do you take on another situation, one that's only slightly more difficult than the first one, and stick with it until the distress evaporates. This process is continued until you have been thoroughly exposed to all of your obsessions, including what you initially estimated to be the most frightening. By the time you get to it, you will have been desensitized by the exposure exercises leading up to it, so that the final step will be no more difficult than the first one. This process, moving toward a goal in small steps, is an important part of the recovery process.

For exposure to succeed in erasing the fear, there are two necessary conditions. First, rituals and any other means of dodging the exposure must be prevented. The use of false fear blockers will be fully discussed below. For now let's discuss the second of these conditions, the need for prolonged exposure. Exposure sessions must be long enough for you to experience a noticeable decline in your distress during the exposure. This means your sessions could be for an hour or more. What people typically feel during their sessions is a gradual rise in distress, which levels off after several minutes. Then it starts to decline. It is during this phase that you're receiving the benefits of the exercise. Whatever the trigger, it's losing its power to provoke fear. With the next exposure session, and subsequent ones, you'll find that the fear at the beginning is lower and falls away faster, until eventually you'll feel little or no distress. You will have neutralized the trigger, and learned that exposure alone will free you from anxiety without resorting to the use of faulty fear blockers

Keep your exposure sessions to no more than 90 minutes by selecting triggers that are in the mild to moderate range of difficulty. Exposure can be mentally and emotionally draining, so you don't want to cause an unnecessary hardship by overdoing it. If you underestimate the power of a trigger and find that it's taking more than 90 minutes for the distress to decrease, stop working on it and replace it with an easier exercise. You can return to the one you underestimated after the easier exercises have desensitized you.

As mentioned above, exposure exercises can be in reality or in imagination. Exposures in reality aim to eliminate obsessions triggered by situations in the real world, your physical and social environment. Exposure activities of this kind require being physically involved with situations that trigger obsessions. Exposures in imagination aim to eliminate obsessions triggered by thoughts and images of imaged dreaded future events that are impossible and improbable. Exposures of this kind, since they exist only in your mind's eye, require contact with the imagined triggers. One of the best ways to do

(continued on page 12)

Self-Directed Treatment

(continued from page 11)

exposure in imagination is by writing down the content of your obsessions and recording this scenario on audiotape and listening to it repeatedly for as long as it takes to feel some relief. You can also practice exposure to this scenario by rewriting and rereading it for extended periods of time, again, until you feel your distressed lessening.

For both types of exposure exercises, it is of the utmost importance that you do not stop them while your anxiety is up. If you do, desensitization is prevented and you can even be further sensitized to the situation you're trying to neutralize. With this in mind, schedule your exposure sessions at times when you have enough time to complete them, and know that you will not be interrupted, or distracted. The best results are obtained when you practice every day, including weekends and holidays. A momentum develops that makes the practice easier with faster results. I also recommend that you do the exercises early in the day. This way you're less likely to put them off and the thought of doing them is not hanging over your head like the sword of Damocles for the bulk of the day.

Ritual Prevention: Refraining from False Fear-Blocking Behavior

A false fear blocker is any action or thought immediately following an obsession that reduces the fear. I use the term "false" because the reduced fear is only temporary and returns with the next obsession. Its greatest harm is blocking exposure, which prevents recovery.

The most common false fear blockers are: physical and mental compulsions; distraction; avoidance; and reassurance seeking.

Physical and mental compulsions are voluntary actions that are under your control. Just as you can control the movement of your muscles, you can control the performance of physical rituals. The same is true for mental rituals; they are willful words that you say to yourself and images that you purposely produce. The question isn't, "Can I prevent rituals?" but, "Am I willing to prevent them?" If you wish to overcome OCD the answer must be "yes." The price you'll pay for giving them up – short-term, mild anxiety – is well worth the long-term benefit of freedom from OCD. The old saying, "It's easier than you think," has been found to be true by all the courageous people who have abandoned rituals and overcome their suffering. You can be one of them. Remember that by shaping your exposures you can control your anxiety level, which will make it easier to relinquish the rituals.

Distraction is probably one of the first false fear blockers people use to cope with obsessions. By trying to get their minds on something else, they hope to ignore obsessions with their attendant anxiety and distress. Really paying attention to what they're doing, constantly being busy, and keeping on the move are ways those of a more energetic bent may use to compete with repetitive, intrusive thoughts and images. Listening to music, chattering incessantly and mindlessly are resorted to by others attempting to dampen the impact of obsessions. Those with the tendencies to worry may even concentrate on troublesome problems of everyday life in efforts to push their obsessions out of mind. The most drastic and decidedly dangerous distraction is inflicting self-injury, frequently to the head, as if to drive out demons, expiate guilt, or exchange physical pain for emotional anguish. Distractions, like their fear blocker cousin, compulsions, only offer a frequently unpredictable, short term let-up from the distress of inevitably recurring obsessions. Distractions must be abandoned so that the genuine fear blocker can work – exposure.

Avoidance – as you know by now – is the opposite of exposure and prevents recovery. Prior to having this knowledge, however, you did what came naturally and stayed away from triggers that activated irrational thoughts, images and impulses. Now, you need to take the path to recovery, the one that follows the fear. If you stray from it and wander into the wasteland of avoidance, your journey will be without end. Or, as one of my patients said, "I get it. The idea is to be like a heat seeking missile, fix on the fear, follow it, and blow it up."

Avoided situations can be your ally when you recognize that they are actually triggers for your obsessions, and as such, targets for desensitization. When they have been neutralized, and you are able to easily approach them, you will have demonstrated the ultimate proof of a successful treatment outcome.

Reasoning is probably the most commonly used fear blocker even though the person realizes, most of the time that their fears are unreasonable. However, during severe OCD spikes, this understanding weakens and doubts arise that the dreaded thoughts could be real. For example, could the thoughts really mean that "I have a major character defect or that I am crazy?" Just as nature abhors a vacuum, humans abhor uncertainty. We deal with it by rationalizing, analyzing, intellectualizing, theorizing, and using all kinds of mental manipulations attempting to achieve certainty. This happens in OCD when the faulty fear blockers of reasoning, "thinking things through," and challenging irrational thoughts are called into play. As you already know, these efforts at relief are futile. We have little direct control over our emotional reactions because emotions happen to us, they're not things we will to happen. Our rational control of fear is weak; but fear can easily hijack rational control, doing so routinely in OCD. This is because the connections from the brain's emotional systems to the rational systems are stronger than connections from the rational systems to the emotional systems (LeDoux, 1996). Philosophers, poets, and other sages have expressed this understanding over the centuries, and joining them today are neuroscientists reporting discoveries about how the brain works. Remember, with fear, what you think won't help you, but what you do will.

Reassurance is one of the most powerful and unrecognized of these fear and recovery blockers. It's a form of compulsion that I've found in over 90 percent of the people I've worked with. Because so many compulsively seek reassurance to calm their OCD and anxiety, it deserves special attention.

People with OCD worry that their obsessions might come true. To ease this distress they ask other people, usually family members or close friends, over and over again to reassure them that their fears will not materialize. Because obsessions are always unrealistic, the family members or friends (and even therapists) tell them there is no need to worry; nothing bad is going to happen. For instance, it is quite common for people with fears of being irresponsible or careless to seek reassurance that they are neither. Typically they get the reassurance that they want, and temporary relief; but like other compulsions, reassurance blocks recovery. This is the first paradox. Reassurance is not helpful – it's harmful. However, the short-term relief it provides is rewarding enough to keep the person repeatedly seeking more, which is the second paradox. The more reassurance received, the more reassurance wanted. Trying to satisfy the demand is like trying to fill a bottomless pit.

In addition to hindering recovery, incessant requests for reassurance can grow to be overbearing demands that lead to interpersonal strife. In one case, after her hus-

band's demands became so intense and frequent, one woman actually moved out and rented an apartment of her own. Her husband entered an intensive treatment program where both were helped and the reassurance stopped. This is an example of the third paradox. Once reassurance is eliminated, the reassured finds no further desire for it accompanied by a decrease in their obsessions and other compulsions. How, then, should you handle your urges to ask for reassurance?

First. Stop asking for reassurance. Identify your most frequent questions and do not ask them. Avoid subtle, indirect ways of getting reassurance. These may be unknown to the reassurers, but knowingly practiced by you. For example, one client I worked with would abruptly stop doing whatever she was doing, sit down and space out. Her husband learned that these behaviors signaled that she was caught up in obsessions; and unbeknownst to him, they became a nonverbal request for reassurance that he would immediately provide. It was his cue to begin telling her not to worry, that her fears were irrational, that it was only her OCD. So in addition to attending to the obvious requests, subtle indirect ones also need to be stopped.

Second. Educate your significant others about the harmful effects of reassurance. Have them read this passage. Explain that providing reassurance interferes with recovery.

Third. Create a gentle refusal statement. At first, you will most likely continue to seek reassurance despite your efforts to abstain from it. Therefore, people from whom you typically get reassurance need to work with you to create a palatable way to say no. One way of doing this is for them to say, "I think you're asking for reassurance. Remember, reassurance is not helpful; it's harmful. Therefore I'm not going to respond." However, if this doesn't work, it's possible that the agreed upon statement itself has become reassuring, or that you believe that nothing bad will happen because the reassurer would warn you. In this case, the best way to end it is for the parties to stop talking about OCD entirely.

Awareness

I guess everybody's heard that you must face your fears to overcome them. That is easy to say but hard to do. Our instinctive reaction in the face of threat is fight or flight. This reaction has survival value for dealing with true dangers, but not for the false dangers you fear with OCD. Survival for you is overcoming OCD, which requires experiencing the fear, sticking with it, immersing yourself in it, and subduing it. Reading this may stoke anticipatory fears, but keep in mind that you can control your fear levels by approaching the triggers gradually so that you feel only mild to moderate levels or of anxiety. On making contact, you might notice that the fear gradually rises but then levels off, and after a while it begins to decrease. It is during this last phase that you are getting the benefits of treatment. You are being desensitized.

While facing the fear, your task is to pay attention to your uncomfortable thoughts, and emotional and physical sensations. Dwell on the scary thoughts and images. Do the opposite of what you have been doing and accept the fears as being possible. Imagine the dreaded future events happening. Say to yourself, "So be it." Concentrate on the prospect of living in a world of uncertainty, of never knowing if and when something bad is going to happen, of never getting over the anxious condition, and so forth and so on. Keep thinking about thoughts and calling up images to deliberately provoke fear. In this way you are using fear to fight fear. You can't overcome fear by trying to go around it but only by going through it. Really be aware of the emotions you are experiencing.

Also notice your body's physical reactions. Where do you feel the anxiety in your body? If your heart is beating faster and harder, tune in to it. If you have muscle tension, focus on that. If you're breathing faster and harder notice it. Are your stomach and chest tight? Do you feel hot? Are you sweating? If the answer is yes, it means that you are on the right track because you're feeling the fear and letting it burn itself out. By pursuing the fear, you are destroying it. Exposure is to obsessions and compulsions as sunlight is to vampires. All of these bad feelings are for the good. You'll know this for yourself when, after several exposures, the fear no longer exists. You won't be able to summon it even if you try.

However, you might be concerned that the obsessions will become stronger if you give up your efforts to stop blocking them or if you deliberately bring them on. Or you might worry that whatever you dread will happen. Paradoxically, neither of these outcomes occurs. Instead, the exact opposite happens; you will recover as a result of re-training your brain's fear system to stop making false alarms about harmless events. You will be desensitized to the previous fear triggers and see them as they truly are – harmless thoughts and images that are simply part of the normal flow of your stream of consciousness. In other words, OCD is erased when the unwanted thoughts, images, and impulses are faced, and embraced.

You may ask, "If exposure to fear is all that's required to get over OCD, why hasn't this already happened? I've had these obsessions for many years and they just keep coming." The answer is that you have used futile fear blockers to cut off distress from the obsessions. This means that your exposures to the fear haven't been long enough for it to naturally drop, which it will, simply as a result of your feeling it. You will fully understand the truth of this after you've completed your first exposure exercise.

The above exercises may seem daunting. But keep in mind the benefits they offer:

- Changes in emotions from high anxiety to little or no anxiety
- Rational thoughts replace irrational ones
- Ability to maintain employment, volunteer activity, or pursue education or training goals
- Chance to engage in normal interests and routines
- Ability to enjoy satisfactory family and social activities and relationships

Good luck. You've got the power!

Reprinted with permission by New Harbinger Publications, Inc.
Overcoming Compulsive Checking,
Munford
www.newharbinger.com

Paul R. Munford, Ph.D. is a clinical psychologist and director of the Cognitive Behavior Therapy Center for OCD and Anxiety. He is also the author of *Overcoming Compulsive Checking: Free Your Mind from OCD* and *Overcoming Compulsive Washing: Free Your Mind from OCD.*

Bulletin Board

(continued from page 2)

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.

OCD, BDD, Hoarding Study

The University of California at San Diego Obsessive Compulsive Disorders Program is looking for people with Obsessive Compulsive Disorder (OCD), Body Dysmorphic Disorder (BDD), and Compulsive Hoarding to take part in a study that is providing:
1. 12 weeks of free medication treatment
2. Brain imaging scans (PET & MRI)
3. Diagnostic Evaluation
4. Neuropsychological Evaluation
For more information call Dr. Jennifer Sumner at (858) 534-8056

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.

Do you suffer from obsessive compulsive disorder?

Participants Wanted

Research Study on the Effectiveness of Duloxetine (Cymbalta) in Treating Obsessive Compulsive Disorder. Dr. Darin Dougherty of Massachusetts General Hospital OCD Clinic and Research Unit is conducting a research study on the use of duloxetine (Cymbalta) to reduce the symptoms associated with obsessive compulsive disorder (OCD). If you have OCD, you may be eligible to participate in this study.

To be eligible you must:

- be between 18-65 years old.
- live within 1 hour of Boston .
- be able to participate for 17 weeks.
- not be pregnant or breastfeeding.

If you are interested in this study and believe you are eligible, please contact Mariko Jameson at (617) 726-9281.

Drug Study for Hair Pullers

Do you pull your hair? Is it causing problems? Does it feel out of control? We are currently seeking volunteers for a drug study for hair pulling. Participation is confidential and requires visits to our Minneapolis, MN site. Please email or call if you would like more information.

Brian Odlaug, Research Coordinator, Department of Psychiatry, University of Minnesota, (612) 627-4363 (confidential line), email: odla0019@umn.edu.
Jon Grant, M.D., Department of Psychiatry, University of Minnesota, (612) 273-9736 (confidential line), email: grant045@umn.edu.

Study of Perception in BDD and OCD

Dr. Fugen Neziroglu and Dr. Yaryura-Tobias at the Bio-Behavioral Institute in Great Neck, NY, are studying differences in perception between people with Obsessive-Compulsive Disorder, Body Dysmorphic Disorder, and healthy controls, especially with regard to appearance related perception. Greater understanding of perception in these populations could aid in designing therapies that better target the factors that contribute to the disorders. Participation is open to anyone with OCD or BDD, or without any psychiatric diagnosis. Participants need to allow us to photograph them. Participants receive feedback as well as compensation.
The Bio-Behavioral Institute is located in Great Neck on Long Island, NY. For more information or to sign up, call and speak with Natalie or Jonathan at (516) 487-7116. Information is also available on our website: www.bio-behavioral.com/home.asp

Research Survey About Repetitive Behaviors in Children and Adolescents

Help us understand more about the repetitive behaviors exhibited by children and adolescents with obsessive-compulsive disorder (OCD)!

The University of Alabama Psychology Department is beginning a new study of repetitive behaviors in children and adolescents with OCD as part of a graduate student dissertation. We are interested in families with children between the ages of 7 and 17 years of age. This study examines repetitive behaviors, social interactions, and fears or worries in children with OCD and will provide valuable information for future research and clinical interventions with families of children with OCD. For example, the results from this project may be applied to developing individual and group interventions for children and adolescents with OCD.

Participation involves completing a 30-minute telephone interview and then filling out an internet-based survey regarding your child's behavior, which will take approximately 1 hour and 15 minutes to complete. You will receive an ID number and password for the internet-based survey and may complete it at your convenience. Once you have completed the survey, you will receive a $5 gift certificate to a major bookstore in your area as a thank you for your time.

If you are interested in participating in this study, please contact Michelle DeRamus, a graduate student supervised by Dr. Laura Klinger, at (205) 348-9312 or by email at repetitivebehaviors@gmail.com for more information.

Compliance with Solicitation Regulations

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

A copy of OCF's most recent financial report is available upon request and may be obtained at no cost by writing to OCF at P.O. Box 9573, New Haven, Connecticut 06535-0573 or by contacting its Executive Director at (203) 401-2074. If you are a resident of one of the following states, you may obtain information directly as follows: **Florida**: A COPY OF THE OFFICIAL REGISTRATION AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE FLORIDA DIVISION OF CONSUMER SERVICES BY CALLING TOLL FREE WITHIN THE STATE (800) 435-7352, OR (850) 488-2221 IF CALLING FROM OUTSIDE FLORIDA. OCF'S REGISTRATION NUMBER IN FLORIDA IS CH8507. **Maryland**: A copy of the documents and information submitted by 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.

REGISTRATION WITH A STATE AGENCY DOES NOT CONSTITUTE OR IMPLY ENDORSEMENT, APPROVAL OR RECOMMENDATION BY THAT STATE.

THE OCF DOES NOT HAVE A PROFESSIONAL SOLICITOR. ONE HUNDRED PERCENT OF EVERY CONTRIBUTION IS RECEIVED BY THE OCF. DONATIONS WILL BE USED TO UNDERWRITE THE OCF'S PROGRAMS, ACTIVITIES AND OPERATIONS AS WELL AS FOR RESEARCH.

Name _____

Address _____ City _____

State _____ Zip _____ Telephone (_____) _____ Email Address _____

❑ Please renew my membership in the OC Foundation

❑ I wish to become a member of the OC Foundation

❑ $45 Individual Member (Canadian $50US, Outside the US $55US) ❑ $65 Family Membership (Canadian $70US, Outside the US $75US)

❑ $85 Professional Member (Canadian $90US, Outside the US $95US) ❑ **Additional Donation $ _____**

❑ Matching gifts from your employer (please enclose forms)

Credit Card Payment Authorization: For your convenience, we accept Visa, MasterCard, American Express and Discover.

Please check method of payment : ❑ VISA ❑ MASTERCARD ❑ AMERICAN EXPRESS ❑ DISCOVER

Credit Card #_____Expiration date _____

Amount $_____ Signature _____ Date _____

Please enclose payment. Checks should be made payable to OCF, Inc. and mailed to:

OCF, P.O. Box 9573, New Haven, CT 06535

Telephone: (203) 401-2070 Fax: (203) 401-2076 E-mail: info@ocfoundation.org

ADDITIONAL DONATIONS TO SUPPORT OCF'S WORK ARE GRATEFULLY ACCEPTED.

You may photocopy form to keep your Newsletter intact.

www.ocfoundation.org

OCF
P.O. Box 9573
New Haven, CT 06535

Address Service Requested

Time-Sensitive Material — DO NOT DELAY!

Non-Profit
U.S. Postage
PAID
New Haven, CT
Permit No. 337