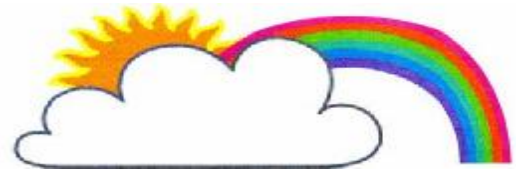
A Newsletter Dealing with Obsessive Compulsive Disorder

NEVER say NEVER

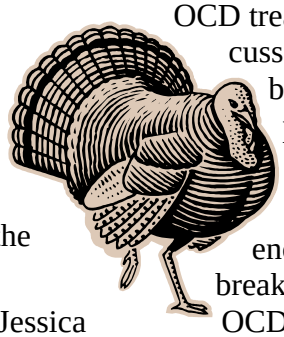


In the midst of the seemingly endless storm,
look to the promise of the rainbow -
the rain shall not prevail!

Fall 2004

THE PROS TALK TURKEY

We talked in the last issue about the value of information, and the various sources through which we might obtain it. In this issue, we feature two major articles on Cognitive Behavioral Therapy (CBT) and Exposure and Response Prevention (ERP). We hear these terms, and we are told that they are the treatment of choice for OCD. But unless we have undergone such treatment ourselves, we don't really understand what the process involves. On page 4, Ann Arbor therapist Laurie Krauth gives us a detailed and comprehensive view of the ERP process through the eyes of the OCD sufferer.



On page 9, Drs. Antonia Caretto and Jessica Harrell begin a three-part series on "Obstacles to Treating OCD". Those of you who were able to attend the Fourth Annual Rainbow Luncheon on October 2nd heard their wonderful presentation on the subject. In Part 1, Drs. Caretto and Harrell describe the nature of compulsions and rituals and explain the premise of ERP as it relates to OCD treatment. In our next issue, they will discuss the difficulties and challenges faced both by the OCD sufferer and the therapist.

Also look for an article summarizing one of the sessions at the OCF Conference back in July. There are some exciting breakthroughs on the horizon in the area of OCD medication.

BEST WISHES FOR A HAPPY HOLIDAY SEASON

AND A NEW YEAR FILLED WITH

GOOD HEALTH, HAPPINESS, LOVE, AND PEACE

FROM THE OCD FOUNDATION OF MICHIGAN

THE OCD FOUNDATION OF MICHIGAN

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**YOUR NAME COULD BE HERE.
WHY NOT VOLUNTEER?**

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To submit articles or letters, write or e-mail the OCDFM at the above addresses.

LIST OF SELF-HELP GROUPS

ANN ARBOR:
2nd Wednesday, 6:30-8:30 PM
Washtenaw County Community
Mental Health
Call Mary Jo at (734) 761-9167

DEARBORN:
1st Thursday, 7-9 PM
First United Methodist Church
Garrison and Mason Streets
Call (313) 438-3293

FARMINGTON HILLS:
1st and 3rd Sundays, 1-4 PM
Trichotillomania Support Group
Botsford Hospital
Administration & Education Center,
Classroom C
28050 Grand River Ave. (North of 8 Mile)
Call Bobbie at (734) 522-8907

FLINT:
1st and 3rd Thursdays, 7-9 PM
Perry Center
11920 S. Saginaw St.
Grand Blanc
Call Mario at (810) 743-8508

GRAND RAPIDS:
Every other Wednesday, 7-9 PM
OCD and other Anxiety Disorders
Dominican Center, Marywood Campus
Fulton Street
Call Mike at (616) 957-5119

HOLLAND:
For information, call:
Geraldine at (616) 335-3503 or
Tony at (616) 396-5089

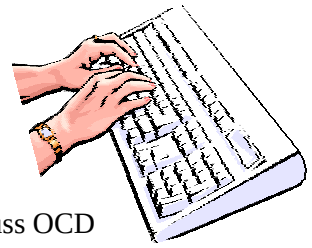
LANSING:
1st and 3rd Thursdays, 7:00-9:00 PM
Delta Presbyterian Church
6100 W. Michigan
Call Jon at (517) 485-6653

ROYAL OAK:
1st and 3rd Tuesdays, 7-9 PM
St. John's Episcopal Church
115 S. Woodward at 11 Mile
Call Cyndi at (248)-541-0782

SPRING LAKE / MUSKEGON / GRAND HAVEN:
1st and 3rd Mondays, 7-9 PM
Spring Lake Wesleyan Church
Classroom E-111
Call Pam at (231) 744-3585

CLEVELAND, OHIO:
2nd and 4th Thursdays
Call Mary Ann at (440) 442-1739

ONLINE SUPPORT



OCD-Support (http://health.groups.yahoo.com/group/OCD-Support)
This is a very large and well-connected support group. Among its many members are doctors and treatment professionals who respond to questions.

OCD-Family (http://groups.yahoo.com/group/OCD-Family)
This is a mailing list for the loved ones of OCD sufferers, a safe place to discuss OCD and the way it affects the family as well as the sufferer. Its purpose is to help learn new ways of dealing with OCD from a second-hand perspective and to learn how to help our loved ones. It is asked that OCDers themselves not subscribe to this list.

Organized Chaos (http://www.ocfoundation.org/1000)
For teenagers/young adults only, this is a site for learning about OCD from each other, and from treatment providers.

OCD TREATMENT: FIGHTING BACK

By Laurie Krauth, MA, LLP

A young executive can't wear clothes until they are put on "just right." He loses his job because it takes him so many hours to get dressed.

A new mother is terrified that her blasphemous thoughts will kill her infant. So she stands over his crib repeating, "I love you Jesus" six times. If she's distracted by a thought of the Devil or the sound of a passing car outside, she starts again. And again.

A football coach is afraid that his favorite aunt will die in a car crash if he does something wrong—but "wrong" keeps changing so he has to stay on his toes. One day "wrong" means thinking of her as he puts on his favorite Lions jersey; the next day it means picking up a box of cereal at the grocery store with an "expires by…" date that adds up to his aunt's birthday.

No wonder Obsessive Compulsive Disorder is called the "doubting disease." Your obsessive thoughts cause your anxiety to soar. You try to calm yourself by doing rituals that make no sense to you intellectually. Still you shudder at the thought that if you don't do what the OCD is telling you to do, something will go wrong—someone you love will be hurt, your day will be ruined. There will be dire consequences to someone, somewhere.

No matter how smart, logical, or compassionate you are, you are blackmailed by the thought, however irrational, that the OCD may be telling the truth and the stakes are too high to ignore it.

"My house could burn down if I don't check the burners and knobs on the stove for half an hour," you think to yourself. *"Really, how can I resist the time and effort involved in my rituals if there's the slightest chance they really will protect my loved ones or me?"*

Yet you've had enough of being blackmailed by your OCD. You want your life back. After great thought, you decide to take on your OCD and go through the painful, exhilarating process of gaining mastery over your symptoms. You understand that you may never be entirely free of your obsessive thoughts, that you may find, in periods of stress, that your OCD regains some strength. But you know you can minimize its place in your life overall.

You've found a therapist who specializes in the treatment of choice for OCD: cognitive-behavioral therapy, or CBT. She tells you she's going to work with you using a specific kind of CBT with yet another set of initials, called exposure and ritual prevention, or E/RP.

"Your mind and body have been held hostage by your OCD symptoms but you *can* choose to fight back," she explains. "You can break the connection between your anxiety-producing obsessions and the irrational rituals meant to eliminate them. Then you can see, first-hand, that nothing bad happens."

"But I've tried to fight back a million times," you reply. *"I always end up back in the throes of my OCD."*

"I'm sure you've tried hard to fight your OCD," your therapist agrees. "We're going to use that motivation of yours and help it along with a structured, systematic program that will allow you to confront your fears without ritualizing.

"In the past, your battle against the OCD has been like that of a would-be swimmer who jumps in a pool, finds the water freezing, and jumps out. He tries again every week, but always climbs out quickly, feeling too cold," she says.

"But now imagine that he decides he's going to stay in the water until he can stand the cold. With some new mental weapons to handle it, he manages to stay in the pool for an hour at a time. As the minutes pass, he begins to adjust to the temperature. He repeats the exercise several times that day and then every day for the next month. Over time it gets easier; eventually he dismisses his initial "cold" thoughts because he knows he'll stop noticing them shortly. He no longer avoids the water, and when he's in it, he learns he can handle the cold. That could be you with your OCD."

MAPPING OCD'S ROLE IN YOUR LIFE

To start, you and your therapist do a comprehensive assessment, covering your history and other relevant concerns. You both agree you're ready to start tackling your OCD so you examine your symptoms today. You say you worry about harming others, and it shows up in a variety of checking symptoms.

"I'm afraid I'll run people over with my car, and at home I'm afraid I'll burn my house down by leaving an appliance or the lights on, or get us robbed by forgetting to lock the doors or windows," you tell your therapist. *"Every time I drive past a pedestrian, I look back for a body. When I get home, I ask my wife repeatedly to tell me that I couldn't have hit anyone without knowing it. I keep checking the locks, the stove burners, the lights, the electric blanket in the winter and the fans in the summer. It's exhausting—and it makes me feel crazy."*

Your therapist gives you your first assignment. "Over the next week, play detective. Look at your life as though a video camera were following you around. Record on a sheet all of your obsessive worries and notice exactly what you do in an attempt to make them go away."

"*It's even worse than I'd thought,*" you tell her when you return the next week. *"I realized that when I'm driving past someone, I listen for the thump of a body going under the wheel or a scream of pain. When I get out of the car, I even pass my hand over the body of the car to feel for new dents or skin or hair from someone I hit. Then I switch on the news at home to check for any reports of hit-and-run accidents where I drove."*

"Those were behaviors aimed at neutralizing the anxiety caused by the obsessive fear of hitting someone," she explains. "Did you notice any situations or thoughts you avoided so you wouldn't even trigger your OCD?," she asks.

"You bet. I realized that I drive blocks out of my way in the morning so I won't pass elementary school kids walking to school," you say. In the process of stepping back and watching your OCD manipulate you, you discover obsessive thoughts, rituals and avoidance behaviors that have become so habitual that you've stopped noticing them. *"My OCD controls me even more than I realized,"* you say flatly.

USING YOUR MIND AS A WEAPON AGAINST THE OCD

"You've really been bullied by your OCD, haven't you?," says your therapist. "Of course, everybody has bad thoughts—'What if I drop my infant down the stairs?'; 'Did I turn the oven off when I left home?" What makes it hard for you is how long you spend worrying and trying to drive the demons away, and how much that affects your life. Most people let those bad thoughts go: they delete them like spam from their computer or junk mail in their mail box. For you, the thoughts are sticky: they won't let go. The OCD convinces you that your rituals will make the bad feelings go away—they'll make things right, or keep you or someone you love safe--so you keep doing them."

"*That's right,*" you reply. *"It's like a triple whammy. I'm upset by these disturbing thoughts and I'm mad at myself for taking them seriously, but I'm afraid to skip the ritual just in case it really works. Then I'm frustrated with myself for doing things that make so little sense!"*

"The problem is that OCD is like a hungry, barking dog," she comments. "When you do your ritual to make the bad feelings go away, it's like you feed the dog a steak to get it to leave you alone. Instead it just gets bigger and louder and looks tougher and more insatiable. You feel like you better feed it bigger and juicer steaks, more and more often, to keep it from harming you.

"I've noticed that," you exclaim. *"I used to check my rear view mirror once, and now I need to check it three times to get any relief and even that doesn't last. A year ago, when I got home, my wife just had to reassure me once that I couldn't have hit anyone. Now I go back to her a half-dozen times throughout the evening for that reassurance. I keep needing more to keep the fears at bay. I feel like a drug addict."*

"Well," she replies, "you've come in for treatment because you've decided to stop feeding the dog steak: no more rituals to make your obsessive thoughts go away and no more avoiding situations that might trigger those thoughts. You're going to be doing something very different by standing up to that snarling dog. You'll

discover that it's bluffing; it's really a pussy cat who can't hurt you. You're going to label the OCD for what it is: an irrational belief that your rituals offer protection against those awful thoughts."

You ponder that. *"I can see an OCD obsession as a hungry dog that I just make more greedy by feeding with my rituals. And you know what? I can also see it as an annoying mosquito bite. If I accept the itch and refuse to give in and scratch it, the itch eventually goes away. If I scratch it, it gets better at first. But then it gets worse and I just need to keep scratching more and more."*

"Exactly," she replies. "I like that."

PLANNING YOUR TREATMENT STRATEGY

You discuss with your therapist whether to combine medication with the cognitive-behavioral therapy. She explains that a psychiatrist could consult with you about medication; one kind of antidepressant called SSRIs have been found to help about half of all people with OCD. "They help the most when they're combined with CBT. But most people find their OCD symptoms return when they stop taking the medications so an SSRI alone isn't enough, even if it works for you. Therapy is the best tool for long-term change. Many people benefit from combining CBT and medication. It's up to you whether you want to use both," she says.

"Let me think about it," you reply. *"I'll probably schedule an evaluation with a psychiatrist and then consider the options."*

You and your therapist then begin preparations for the exposure and ritual prevention program. Already you have your notes from your own detective work. Together you create a detailed inventory of all your obsessive thoughts, rituals and avoidance behaviors. Then you rank your compulsions by the degree of distress it causes you to experience the obsession and imagine not doing the desired ritual.

From easiest to hardest you list "hit-and-run" driving compulsions, followed by checking lights and various appliances, and finally checking doors and windows. You have many subtle distinctions for each category.

"*In the car, I have the least anxiety when I'm driving on a deserted country road,*" you report. "*My anxiety gets progressively worse driving on the highway, in a neighborhood, driving near a school, driving at rush hour and finally driving through a crowd, like before and after University of Michigan football games. I also realized I get more anxious when I'm tired, rushed, or stressed because of something like a fight with my wife or a stupid assignment from my boss."*

You and your therapist design your first E/RP assignment. "You want to target a situation you really want to change," she says. That will motivate you to do the hard work E/RP demands of you. But you don't want to pick something so overwhelming that you aren't willing to do it."

"*I want to start with driving,*" you reply. Together you make a plan that will be hard—but not too hard. "*Let's see if I have this down,*" you say. *"The first week I'll drive an hour a day on the highway in the right lane, looking for opportunities to drive near cars or people on the side of the road. I won't use my "safety crutches" like looking in my rear-view mirror for bodies after passing someone, checking for dents when I leave the car, or asking my wife to tell me I didn't hit anyone."*

Also, you increase your anxiety by adding exposure to your bad thoughts. You place sticky-notes all over the dash board. They read: "I hit someone." "There's blood on my grill." "I killed someone." You agree that you won't stop doing the assignment each day until you feel less anxious than when you started. You promise to record your anxiety and success for each E/RP session on a form.

You've scheduled a double session with your therapist today so that when you finish your planning, you can go out in the car together. "In this therapist-assisted E/RP, I can help you practice the work you'll be doing on your own," she says, as you walk together to your car. "We'll do something just a little harder than your assignment while I'm here to give you support. That will make your daily homework less daunting."

For the next hour, she sits beside you while you drive on the highway, changing lanes repeatedly to increase

your anxiety about hitting someone and then not looking in your mirrors to check. Your anxiety spikes at first but diminishes over the hour, and you head home confidently to begin your own E/RP.

As arranged, you call your therapist after three days of assignments to report on your progress and to see if you need to adjust the homework to help you succeed. *"It was easier than I expected, but I still glanced back in the mirror several times each day. And I asked my wife for reassurance a few times when I got home,"* you acknowledge.

"That's good information," says your therapist. "Continue the exposure but really put the brakes on seeking reassurance. How about adjusting the mirrors at a slightly awkward angle--just enough to interrupt your reflexive checking? And work hard not to ask your wife for reassurance. How about if we invite her in to the next session so she can learn better how to help?"

At the next appointment, you and your wife discuss the impact of your OCD on you and the family. You and your therapist give your wife a summary of all you know about OCD and its treatment.

"I understand that you reassure him so he'll feel better," your therapist tells your wife. "It may feel awkward at first, but the best way to help is to let him experience the anxiety that comes with exposing himself to his fears. That way he learns that he can handle them and that his fears are unlikely to come true." She helps you and your wife find some possible new lines: "It sounds like your OCD is really getting to you;" "Those old OCD thoughts are getting stuck again," or "It's hard to resist but you're really trying." She adds: "You might feel badly for him, or even get impatient for him to get better faster, but it's up to him. You don't need to be his therapist. All you can do is encourage him and step back."

When your wife leaves, you and your therapist modify your assignment to improve your compliance. "*OK. I'll laminate little post-it notes with the words, "It's not me, it's my OCD" and tape them to my car's rear view and side mirrors to make me more conscious of not checking them*," you say. You also re-commit to zero tolerance of rituals or avoiding situations that bring up your obsessive thoughts. You're more successful this time, and when your anxiety diminishes with this task, you're ready to add a harder assignment that you craft with your therapist.

"*Next I'm going to drive at least an hour a day in areas where I'll probably see pedestrians on the road,"* you summarize at the end of the next session. *"I'm scheduling trips past schools at 8 a.m. and 3 p.m. and past crowds before and after basketball games. When the anxiety goes down with this assignment, I'll move up the list to a more challenging task: driving at dusk, when it's harder to see pedestrians and I get more anxious."*

Within a month you are driving places you hadn't imagined possible without depending on your checking rituals. You're proud and feeling increasingly optimistic about your ability to control your OCD. But you want to make sure this isn't false confidence.

"I wonder if I'm calmer because I'm avoiding those scary thoughts that make me want to check and get reassured," you tell your therapist. "I know a way to find out," she says. So you add another layer of homework: mental exposure to the feared thoughts. She helps you write and then tape-record a script about a worse-case hit-and-run scenario.

You read it to her: *"I hit a bump. I've run over a body. I hear a police siren. They're coming for me. I'm sweating as I pull over on the next block. I check the grill on my car: I see skin, and can smell blood. I turn on the radio; already they're reporting my hit-in-run. I'm sure I'll go to prison."* The story goes on.

You commit to spending an hour a day with twenty minutes each of reading the script, writing it out and listening to it. At first your anxiety spikes, but over time it becomes almost boring *("This is ridiculous: that just wouldn't happen!," you think.)*. Eventually you can drop it from your daily E/RP tasks.

Now you're significantly less anxious during and after each trip out. Over the months you continue moving up the hierarchy to increasingly difficult tasks and mastering them. Still, your progress is uneven, depending on how stressful your life is and other occasional bumps.

"*Sometimes I want to quit,*" you admit to your therapist at a session. "*I'm so much better and sometimes I think I'd rather just accept my progress and make life easier by giving in to a few rituals when I'm having a bad day."*

"I understand," she says. "Standing up to your OCD can be exhausting. And yet if you feed that hungry dog an occasional steak, do you think that would satisfy it?"

"No," you reply. *"And honestly, that's what keeps me going when I'm tempted to take a break. That insatiable dog will always want more and I'm done being held hostage by it. I've gone cold turkey on my rituals and I'm committed to staying with this, but I'm going to need help."*

Together you fine-tune your treatment plan to help you maintain your momentum and get the support you need. Your success motivates you and you continue to gain mastery over your OCD. The work is challenging and time-consuming and you know you still have more work ahead of you. But your courage is bringing you a reward that is life changing and indescribably sweet.

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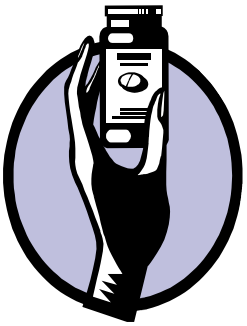
Laurie Krauth, MA, is an Ann Arbor, Michigan, psychotherapist specializing in cognitive-behavioral therapy with anxiety disorders, including OCD. She also treats depression and trauma and works with couples on relationship issues. Links to more information on the treatment of OCD and other mental health issues can be found at www.LaurieKrauth.com. To protect confidentiality, case descriptions in this article are based on composite or fictionalized clients.

NOTES FROM THE OCD NATIONAL CONFERENCE
"Medication Trials: Updates and Prospects"

By Joan E. Berger

Doctor Vladimer Coric, Assistant Clinical Professor of Psychiatry at Yale School of Medicine gave a talk on several drugs that his group has been testing for possible effectiveness in treating OCD. One of these, Riluzole had a positive result. Of nine OCD patients who were given Riluzole, four had noticeable improvement in their symptoms. While this may not seem like a particularly good response to us, the doctors at Yale consider it to be a significant finding, and definitely worth further study.



We are all familiar with the various drugs currently used to treat OCD known as SRI's or Serotonin Reuptake Inhibiters. Serotonin is a neurotransmitter, which is known to have reduced levels in OCD patients. The doctors at Yale University believe that several other neurotransmitters are also involved in OCD. Glutamate is one of these. Glutamate is also known to be involved in ALS, commonly know as Lou Gehrig's disease. It has been approved for the treatment of ALS and has been shown to increase the life span of ALS patients by 6 to 9 months. It may also play a role in Huntington's disease and Alzheimer's. Riluzole works on the brain by inhibiting the production of glutamate available to the brain. Glutamate is a major excitatory neurotransmitter, therefore Riluzole works to calm the affected neurons.

The study lasted 12 weeks, during which time the patients continued to take whatever SRI's they were already on. It is known that Riluzole may affect liver function in some patients; however, liver function returns to normal after the drug is stopped. None of the patients in the study experienced this side effect or any others, and all completed the 12 weeks. Dr. Coric noted that depression improved markedly for these patients during the first few weeks of the study. Dr. Coric also noted that, of the nine participants in the study two were hoarders and both of them were among the four responders. Since hoarders generally have a low response to the SRI's currently used to treat OCD, Riluzole may turn out to be particularly useful to them.

Additional studies of Riluzole are already being planned and the group continues to look for other drugs that may be effective in treating OCD. I'm sure all of us affected by OCD find these results encouraging and look forward to hearing more about the group's work.

Obstacles to Treating OCD: Part 1

Obsessive-Compulsive Disorder and Exposure with Response Prevention

Antonia Caretto, Ph.D. and Jessica Harrell, Ph.D.

In this series of articles about Obstacles to Treating OCD we will address the situations and symptoms which seem to be more difficult to treat. We will discuss techniques that we have used in these cases and explain our thinking behind what works and what doesn't work. The content of these articles is based upon the speech given at the Rainbow Luncheon in October, 2004.

Chances are that if you are reading this article you already have an expert experiential knowledge about OCD. In order to be prepared to identify obstacles to treating OCD and discuss solutions to these obstacles, a more clinical understanding of obsessions, compulsions, and the basics of exposure with response prevention is essential.

Obsessive-Compulsive Disorder has two components. Clinically speaking, obsessions are intrusive thoughts or images that are distressing. Sometimes the person realizes that the thought is not logical or distressing to the average person: "I know that other people don't worry about getting HIV from touching a railing at the mall". Yet others struggle with reasonable obsessions that other people would agree should be of concern: "What if the lamp cord starts an electrical fire?"

Compulsions are rituals used to decrease the distressing anxiety produced by the obsessions. Though they may 'work' short term, paradoxically they worsen and strengthen the OCD. The vicious circle of obsessions and compulsions is like a monster that demands to be fed or a bully that demands your lunch money.

Common among the compulsions are cleaning/ washing rituals and checking. Compulsions can be extremely time-consuming as the sufferer attempts to gain anxiety relief from their intrusive thoughts. Unfortunately, no matter how much time is devoted to ritualizing, it is 'never enough' and fails to produce the desired result.

Another form of ritualizing, which is less observable and more difficult to identify, is avoidance. One might avoid using public restrooms if he experiences contamination obsessions or ask a family member to lock the house if he engages in checking compulsions. Similarly, mental reassurance is a common form of compulsive behavior, like asking a passenger, "Did I hit that person who was standing at the bus stop?" or engaging in reassuring self-talk like, "I know that I did not write anything blasphemous in that e-mail."

Not everyone with OCD identifies with having both obsessions and compulsions. Many people will report compulsions without obsessions: "I just feel like I have to do it" or, "I just have to do it until it 'feels just right'". Another group reports obsessions only: "I just can't get the thought out of my head".

The essential feature that distinguishes diagnosable OCD from 'normal' obsessions and compulsions is not the content of what we think or what we do, but the level of distress and amount of disruption associated with the symptoms. When the anxiety and/or compulsive behavior interferes with a person's social or occupational functioning and has a negative impact on their quality of life, we would consider the symptoms to be pathological and in need of clinical intervention.

The treatment of choice for OCD is Exposure with Response Prevention (ERP). The practice of ERP involves systematic exposure to a hierarchy of anxiety provoking situations coupled with total resistance to performing rituals that, in the short-term, neutralize the distress. In other words, sufferers are asked to endure increasing amounts of anxiety without engaging in compulsive behavior that will serve to strengthen their anxieties. Research indicates that ERP is successful in managing OCD symptoms in 85% of cases.

Learning to tolerate uncertainty is the goal of ERP. Whether that be in accepting that a lock may have been overlooked or that germs are on one's hands. The goal of ERP is not to stop the obsessions from occurring, nor is it to convince OCD sufferers that their feared consequences can not happen. Rather, ERP allows those with OCD to improve the quality of their lives by tolerating the anxiety associated with life's uncertainties.

In the next newsletter we will begin discussing some issues that are particularly challenging in therapy. Examples include difficulty with keeping appointments, chronic tardiness, accommodating behavior by family members, lack of accountability, and age-related challenges.

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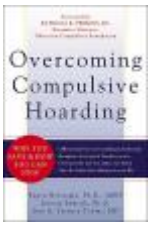
SUGGESTED READING

Paul R. Munford, Ph.D.
OVERCOMING COMPULSIVE CHECKING
New Harbinger Publishers, 2004
(Just released)
ISBN 1-57224-378-3



Fugen Neziroglu, Ph.D., ABBP
Jerome Bubrick, Ph.D.
Jose A. Yaryura-Tobias, M.D.
OVERCOMING COMPULSIVE HOARDING
New Harbinger Publications, 2004
ISBN 1-57224-349-X

Juliana B. Diniz (no degree initials)
Maria C. Rosario-Campos, M.D., M.Sc.
Roseli G. Shavitt, M.D., Ph.D., et al.
"Impact of age of onset and duration of illness on the expression of comorbidities in obsessive-compulsive disorder"
JOURNAL OF CLINICAL PSYCHIATRY
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Arthur J. Barsky, M.D.
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Ross G. Menzies
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The Pediatric OCD Treatment Study (POTS) Team
"Cognitive-behavioral therapy, sertraline, and their combination for children and adolescents with obsessive-compulsive Disorder"
J A M A
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For additional information on obtaining the above books and papers, call The OCD Foundation of Michigan voice mail, (313) 438-3293, and leave a message.

BULLETIN BOARD

CHILDREN WITH OCD SOUGHT FOR A STUDY AT THE UNIVERSITY OF MICHIGAN

Researchers at the University of Michigan are conducting a brain imaging study of children with obsessive compulsive disorder (OCD). Children with OCD, between the ages of 8 and 14 are eligible. The study involves an MRI scan, and in some cases an EEG study, which will occur over 2-3 sessions, each from 2 - 3 hours. A parent needs to accompany the child to all sessions. Families will be compensated for their time at $25/hour. Interested parties may contact Kate at 734-615-8151, or email krd@umich.edu.

HELP WANTED

Do you have a few hours per month, and are you ready to dedicate some time to further the cause of OCD education and support in the State of Michigan? Why not volunteer to join the OCDFM Board of Directors?

YOU CAN MAKE A DIFFERENCE!

Call 313-438-3293 or e-mail OCDmich@aol.com

GIRLS WHO WORRY

NEW GROUP OFFERED BY DR. ANTONIA CARETTO

This group is for girls ages 7-13 who are distressed by intense worries (for example, about the weather, getting sick, or, in general, something bad happening). These worries might make it hard for her to get to school, go to bed, or just be happy.

Dr. Caretto will offer this group to help each girl realize that she is not the only one dealing with such worries. Dr. Caretto believes that group meetings can help each girl

- understand her anxieties, phobias, obsessions and compulsions,
- Share her thoughts and feelings in an environment where peers have empathy,
- learn and practice cognitive and behavioral skills to lessen the distress of these anxieties,
- set goals and enjoy mutual support.

The free pilot meeting for "Girls Who Worry" will be held in Farmington Hills on SATURDAY, JANUARY 8, 2005, 10:30 am - 12:30 pm.

For more information or to RSVP, CALL DR. CARETTO AT (248) 553-9053

PROFESSIONAL DIRECTORY

Business Card Ads Now Available!

Treatment professionals, here's a new way for you to find the OCD sufferers who need your help, and to give them a way to find you. Just place your business card in ***Never Say Never***, the quarterly newsletter of the OCD Foundation of Michigan. For just $25.00 per issue, your card can be in the hands of the very people who need you most. It's a great way to reach out to the OCD community, and at the same time support the OCD Foundation of Michigan. Send your card to OCDFM, P.O. Box 510412, Livonia, MI 48151-6412, or e-mail to OCDmich@aol.com. For more information, call 313-438-3293.

THERAPISTS!!

ADVERTISE WITH US

YOUR BUSINESS CARD COULD BE HERE!

PLEASE HELP

The OCD Foundation of Michigan is funded solely by your annual membership fees and additional donations. We have no paid staff. All work is lovingly performed by a dedicated group of volunteers. WHY NOT VOLUNTEER YOUR TIME? Call 313-438-3293 or e-mail OCDmich@aol.com.

The OCD Foundation of Michigan
Membership Application

Please Print:

Name: _____

Address: _____

City: _____ State/Province: _____ ZIP/Postal Code: _____

Phone Number: _____ E-mail Address: _____

May we send you notices and announcements via e-mail? _____

q **Enclosed please find my check for $20 annual membership fee.**

q **Enclosed please find my tax-deductible donation of $ _____**

Make check or money order payable in U.S. funds to
Terry Brusoe, Treasurer
THE OCD FOUNDATION OF MICHIGAN
25140 Dockside Lane
Harrison Twp., MI 48045-6707

12/2004

Please Don't Throw Me Away

You've finished reading me and don't need to keep me anymore. Or worse (boo-hoo), you don't need me and don't even want me. In either case, please take me somewhere where I can help someone else. Take me to your library. Take me to your doctor, therapist, or local mental health clinic. Take me to your leader. But please, please, don't throw me away.

OCD Foundation of Michigan
Mission Statement

- To recognize that OCD is an incurable neurobiological disorder that can be treated with great results by the reduction of anxiety that OCD creates.
- To offer a network of information, support and education of parents, teachers, friends, family, and the medical community.
- To enlighten state legislators on how this disorder affects the sufferer, on entitlements under the full umbrella of the State Board of Education and the laws of the State of Michigan.

IF YOU WOULD LIKE TO BE ADDED TO OR DELETED FROM THE MAILING LIST PLEASE CONTACT US

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