

**20 Years
of
Service**

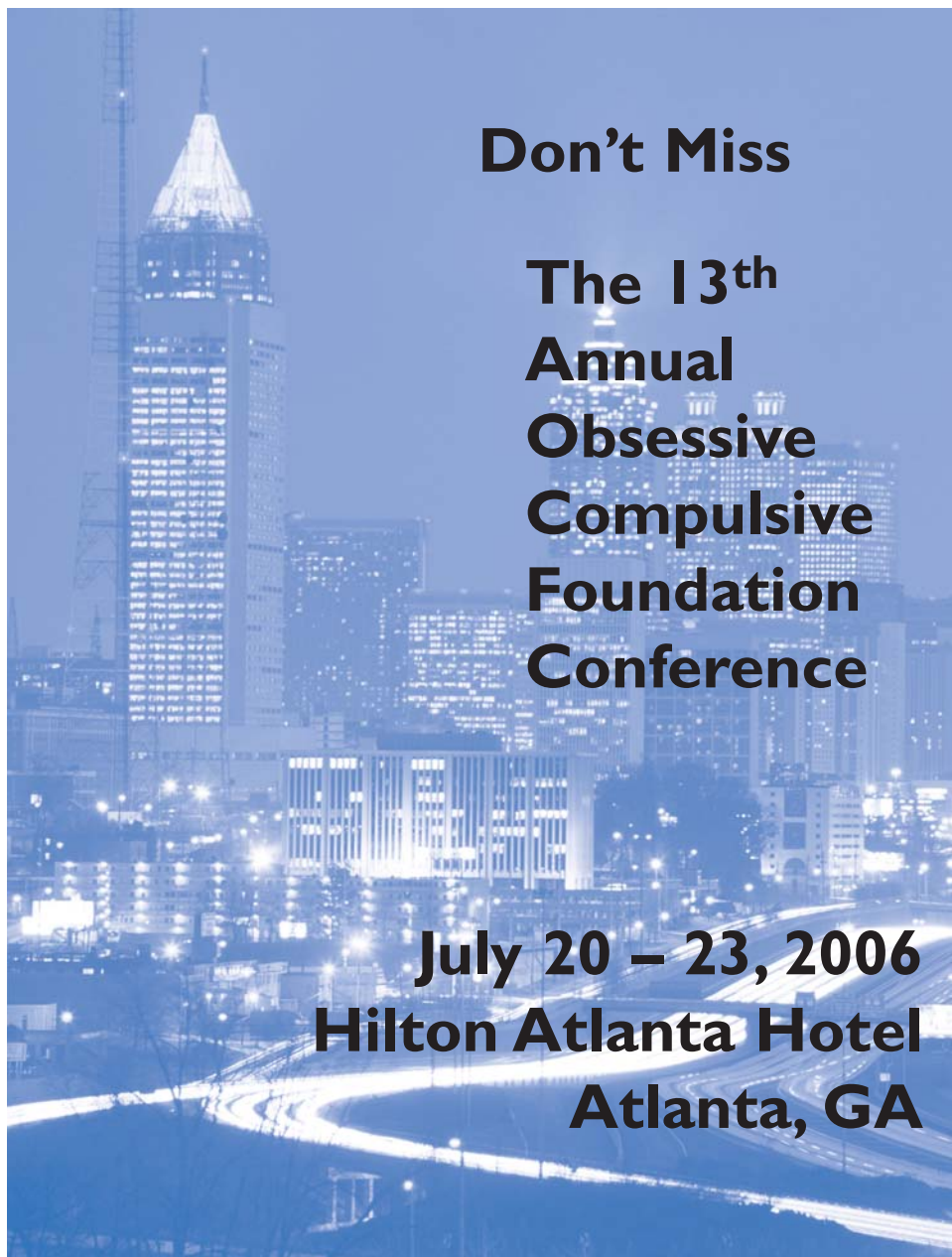
OCD Newsletter

**1986
to
2006**

Volume 20 Number 3

Published by the OC Foundation, Inc.

LATE SPRING 2006



**Don't Miss
The 13th
Annual
Obsessive
Compulsive
Foundation
Conference**

**July 20 – 23, 2006
Hilton Atlanta Hotel
Atlanta, GA**

13th Annual OCF Conference Slated for July 20-23

Registration Brochures for the 13th Annual Obsessive Compulsive Conference are now available. The Conference, which will run from July 20 to 23, 2006, features more than 80 presentations, workshops, seminars and support groups. The Conference will start

sionals interested in compulsive hoarding.

Conference attendees who have preregistered can get their badges on Thursday evening. Everyone else can register on Friday morning. The first sessions of the Conference begin on Friday morning

OCF Gives Seven Research Awards

Research is the cornerstone to understanding more about OCD and OCD spectrum disorders. Now in its 13th year, the Obsessive Compulsive Foundation's Research Program allows investigators to conduct research for causes and treatment options for people with OCD.

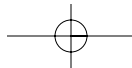
The Review Committee of the OCF's Scientific Advisory Board was faced with a challenging list of outstanding proposals. The winning proposals ranged from researching the role of genetics in OCD to studying how OCD and OCS are related to other disorders. This year, \$331,081 was granted, thanks to donations to the Obsessive Compulsive Foundation, Inc.

Research proposals were reviewed by a committee composed mostly of members of the OCF Scientific Advisory Board (SAB), with final decisions made by Obsessive Compulsive Foundation, Inc.'s Board of Directors. Joy Kant, President of the Obsessive Compulsive Foundation, Inc. Board of Directors said, "We were very pleased with the caliber of the research proposals included among this year's OCF Award winners. Their projects all have the potential to greatly enhance medical knowledge about OCD. Individuals who have donated to the OCF Research Fund can be assured that their contributions are being used to fund worthwhile research." Patricia Perkins,

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In This Issue

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Bulletin Board

ARE YOU THE PARENT OR CAREGIVER OF A CHILD OR ADOLESCENT WITH OCD?

If you are the parent or caregiver of a child or adolescent with OCD, your help is needed. A research project is being conducted to explore the experiences of Pediatric OCD for parents and caregivers. The project involves an interview (face-to-face) with the researcher and then a follow up meeting. The questions are open-ended and will allow those being interviewed to tell the researcher about their experience with their child's OCD. Much information is still needed on the experience of the parent or caregiver in families with a child or teen with OCD. This study is a qualitative study; each of us has a story that needs to be told.

My name is Ann Marie Yezzi-Shareef, MS, LPC, NCC. I am a doctoral candidate in counseling psychology at Gannon University in Erie, PA. This research is in partial completion of my doctoral dissertation. The interviews are essential to the completion of a study on the experience of parents and caregivers of children and adolescents with OCD.

I am willing to travel to meet at your convenience. There will be two meetings. The first is the interview. The second meeting will allow you (parents and caregivers) to meet with the researcher and review what was said and my interpretation. All information will be kept strictly confidential. No information will be used that will allow others to identify you. If you live within 150-200 miles of Erie, PA (this includes Pittsburgh, PA; Buffalo, NY; and Cleveland, OH), please contact Ann Marie Yezzi-Shareef at 814-572-4840. Your child or adolescent will not be interviewed.

OCD AND HOARDING STUDY

The Institute of Living in Hartford, CT and The School of Social Work at Boston University 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 between age 18 and older who have (1) problems with excessive clutter or (2)

symptoms followed by a 4-hour interview about clutter and acquiring. These interviews take place at the clinic. 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 Buck Brady, B.A., at The Institute of Living in Hartford, CT at (860) 545-7574.

DO YOU HAVE OBSESSIVE COMPULSIVE DISORDER (OCD)?

Do you have thoughts or feelings that don't make sense but still make you feel bad? Do you have to do things over and over again? Do you wash excessively or avoid touching things for fear of contamination?

Dr. Alexander Bystritsky at the UCLA Anxiety Disorders Research Program is seeking participants for the following OCD research studies:

Treatment Response in OCD to Sertraline and Aripiprazole as Compared to Sertraline and Placebo

The purpose of the study is to understand if the combination of an SSRI and an atypical neuroleptic started at the same time will achieve a greater or more rapid reduction of symptoms in people with OCD, as compared to the current standard of care. Participants in this study will be randomly assigned to receive sertraline (Zoloft) plus placebo ("sugar pill") or sertraline plus aripiprazole (Abilify) for 18 weeks. Participants will be evaluated every 2 weeks, and doses will be increased as tolerated and as needed. After the 18 weeks subjects will be assisted in continuing their treatment if effective, or finding other forms of treatment. Participants will be compensated for their participation and parking.

Namenda (Memantine HCl) for the Treatment of OCD

The goal of the study is to evaluate how a new drug with an innovative mechanism of action (decreasing glutamate in the brain) affects anxiety. We offer to participants a free

research evaluation of anxiety. This study is 12 weeks and includes 5 visits. The first 4 visits occur every other week and the final visit occurs one month thereafter. Namenda is dispensed at Visit 1 and titrated to a maximum daily dose of 20mg by Visit 3. Participants will be compensated for their participation and parking. To qualify, you must:

- * have OCD
- * be between the ages of 18 and 65
- * not have significant medical conditions

If interested please call the UCLA Anxiety Disorders Research Program recruitment line at 310-794-1038.

BODY IMAGE TREATMENT RESEARCH STUDY

Do you dislike the way any part(s) of your

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OCD NEWSLETTER

The OCD Newsletter is published six times a year.

Obsessive Compulsive Foundation, Inc.

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Joy Kant, President,
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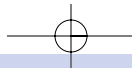
Patricia B. Perkins, J.D.,
Executive Director/Newsletter Editor
Michael Jenike, M.D., Chairperson,
Scientific Advisory Board

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

CORRECTION

In the article "Anxiety Disorders Foundation Offers Funds..." in the Spring Issue of the Newsletter (p. 12), we incorrectly indicated that the scholarship program was part of Rogers

DISCLAIMER: OCF does not endorse any of the medications, treatments, or products reported in this newsletter. This information is for informational purposes only.



Review of “Cognitive Therapy for Obsessive-Compulsive Disorder: A Guide for Professionals”

By Sabine Wilhelm, Ph.D. and Gail Steketee, Ph.D.

Reviewed by Jonathan Abramowitz, Ph.D., ABPP

For many years, the only psychological treatment approach scientifically demonstrated to be helpful for OCD was behavior therapy using the techniques of exposure and response prevention (ERP). Within the last decade or so, however, there is a “new kid on the block” in the form of cognitive therapy for OCD. Indeed, there has been a steady increase in research on cognitive mechanisms and cognitive treatments for obsessions and compulsions, as Sabine Wilhelm, Ph.D., and Gail Steketee, Ph.D., two of the leading experts in the field – describe in their new treatment manual entitled *Cognitive Therapy for Obsessive-Compulsive Disorder: A Guide for Professionals*. Although cognitive therapy does not yet have the strong scientific support that ERP has, it is an up-and-coming treatment that can add to the effectiveness and tolerability of ERP.

What is cognitive therapy? Cognitive therapy is a set of psychological treatment techniques designed to help patients modify problematic beliefs and interpretations (cognitions) that lead to anxiety, obsessions and compulsions. The basic cognitive principle is that one’s deepest beliefs and perceptions about oneself and the world (i.e., core cognitions) dictate how s/he feels and what s/he does in a given situation. For example, if a person habitually views him or herself as highly vulnerable and perceives the world as a very dangerous place, it leads to feeling anxious and engaging in overly protective actions to guard oneself against possible harm. People with OCD (which is an anxiety disorder) display a number of similar problematic cognitions that are targeted in cognitive therapy, such as, the tendency to overestimate danger and personal responsibility, the desire for absolute certainty and perfection, and the tendency to overestimate the importance of (and need to control) one’s own thoughts. Wilhelm and Steketee explain that when a person holds these kinds of cognitive sets, normal intrusive thoughts develop into obsessions, and compulsive rituals develop as a way to pro-

sionals interested in using cognitive therapy strategies for individuals with OCD. The book’s opening chapter outlines the cognitive features of OCD and how these are relevant to cognitive therapy. This chapter provides a nice framework for the rest of the book, which covers the basic structure of treatment, assessment issues, and the application of cognitive techniques with individuals who suffer from OCD. A nice feature of this book is that although it is meant to be used as a treatment manual (i.e., to guide treatment), it does not present a rigid session-by-session cookbook for doing therapy. Instead, each chapter is dedicated to a particular domain of problematic beliefs (e.g., perfectionism or the tendency to misinterpret the significance of intrusive thoughts) and the strategies that best help patients to correct such beliefs. This format highlights the importance of assessing for the types of maladaptive cognitions that must be addressed in therapy – a topic well covered in the opening chapters of the book.

Another impressive feature of the book is that the authors include self-report assessment scales and other forms and handouts for the therapist and patient to use during therapy. Moreover, these forms and treatment techniques have been scientifically tested in research conducted by the authors and funded by the National Institute of Mental Health. The various cognitive techniques include both didactic and Socratic discussion, as well as behavioral experiments that are designed to help patients gather evidence and test the logic of their belief systems. These techniques are clearly described and illustrated with case examples, making the book easy to adapt to patients across the broad spectrum of OCD symptoms (e.g., washing, checking, severe obsessions and mental rituals). This book occupies a prominent place on my bookshelf and I refer to it often when implementing cognitive therapy strategies in my practice.

Recognizing that the cognitive therapy strategies so nicely outlined in this guide can be used in concert with exposure therapy

13th Annual Conference

(continued from page 1)

to Jeannette Cole, deputy director and Conference coordinator, “the meeting where people from all parts of the OCD Community come together to share knowledge, experience and expertise.”

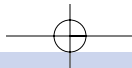
“The topics,” according to Patricia Perkins, OCF’s executive director, “covered in the more than 80 scheduled sessions, include everything related to OC and the OC spectrum disorders from descriptions and explanations of symptom-specific OCD to the latest research on the causes and treatment of OCD.”

When asked who should attend the Conference, Ms. Cole stated: “Anyone who is affected by OCD and/or the OC spectrum disorders should attend.” She added that the Conference has programs for everyone in the OCD Community which includes people with OCD, their families and friends and the mental health professionals who treat them. CEUs for some treatment providers are also available.

The Conference will be held at the Hilton Atlanta Hotel. There is a block of rooms at a special Conference rate of \$121.00 plus taxes for single or double occupancy. According to Ms. Cole, “the rooms fill up quickly so you should make your arrangements as soon as possible.” Reservations can be made by calling the hotel (800-445-8667) and asking for the special OCF Conference room rate.

For more information on the Conference and a Registration Brochure, call Mary Grande at 203-401-7021, ext. 11, or go to www.ocfoundation.org and download the brochure there.

Celebrate
The Foundation’s
20th Anniversary
by Giving to the
OCF Research



Research Awards

(continued from page 1)

J.D., Executive Director of the OC Foundation is pleased that through the contributions of its members and friends, the OCF will be funding very important research with its 2006 OCF Research Awards.

Award amounts range from \$36,600 to \$50,732. The following is a list of the 2006 award winners and their projects:

Paul Arnold, M.D., Centre for Addiction and Mental Health, Toronto, Canada

Genetic Studies of the NMDA Regulatory Network in OCD Including Neuroimaging Endophenotypes

Dr. Arnold's research seeks to investigate the genetic factors associated with early onset OCD in individuals. The research will also assess whether those genes will detect brain abnormalities using magnetic resonance imaging (MRI). Early onset is defined as OCD symptoms that appear before age 15. Arnold notes that prior research of twins and families show that genetics are causal factors in OCD but the study of individuals should shed light on genetic identification and early onset OCD. According to SAB reviewer Dr. Gerald Nestadt of John Hopkins University Hospital, "identification of causative genes for OCD is paramount."

Dr. Arnold, the principal investigator for this study, is a fellow in the Neurogenetics Section and Children's Mood and Anxiety Disorders Service at the Centre for Addiction and Mental Health at the University of Toronto. SAB reviewer Dr. Sanjaya Saxena notes that "the study is quite likely to provide useful knowledge about the genetics of OCD."

Linda H. Chaudron, M.D., M.S., Department of Psychiatry, University of Rochester Medical Center, Rochester, New York

A Prospective Pilot Study of Perinatal Obsessive Compulsive Symptoms (OCS) and Obsessive Compulsive Disorder (OCD)

Dr. Chaudron's study seeks to examine associations between pregnancy and Obsessive Compulsive Symptoms (OCS) and OCD. In her proposal, Dr. Chaudron comments on the range of emotions women may experience during pregnancy and the months immediately following

Chaudron, is highlighted not only by the limited data in this area, but by those studies that prove "maternal anxiety during pregnancy can negatively affect a fetus and result in long-term disturbances for children."

Dr. Chaudron is an Assistant Professor of Psychiatry, Pediatrics, and Obstetrics and Gynecology in the Department of Psychiatry at University of Rochester Medical Center. Jonathan Abramowitz, Ph.D., an SAB reviewer, agrees that "very few studies on the prevalence of OCD/OCS in postpartum samples exist." Bradley C. Riemann, Ph.D., also an SAB reviewer, enthusiastically supports Chaudron's study. "Overall, this proposal is strong. It would provide important, meaningful data in an area of OCD that is under researched."

Vladimir Coric, M.D., Yale University School of Medicine, Connecticut Mental Health Center, New Haven, CT

A Double-Blind, Placebo-Controlled Trial of N-acetylcysteine in SRI-resistant OCD

Dr. Coric's research seeks to discover whether N-acetylcysteine (NAC) will supplement the effectiveness of serotonin reuptake inhibitor (SRI) medications in those patients who appear to be resistant to SRI treatment. Since so many individuals with OCD are resistant to existing treatment options, Coric contends that "SRI-resistant OCD is a major public health problem" and stresses the need for "well-tolerated, less invasive, and more [effective] treatments."

Dr. Coric is an assistant clinical professor in the Department of Psychiatry and director of the Yale University OCD Clinic of the Yale University School of Medicine. John H. Greist, M.D., an SAB member and Co-Director and Distinguished Senior Scientist at the Madison Institute of Medicine, Inc., supports Coric's research, stating that "the medication for the proposed study is more widely and economically available and better tolerated" than other medications.

Lorin Koran, M.D., M.S., Department of Psychiatry and Behavioral Sciences, Stanford University Medical Center, Stanford, CA

Double-Blind Trial of Acute and Intermediate-Term Dextro-amphetamine versus Caffeine Augmentations in Treatment-Resistant OCD

Dr. Koran will study the use of dextro-amphetamine versus caffeine for OCD

reducing OCD symptoms than caffeine, which has not been proven to affect OCD. It is well-known that not all OCD sufferers respond to SRIs (serotonin reuptake inhibitors) or CBT (cognitive behavior therapy). The researcher adds that "treatment-unresponsive patients have substantial impairment in functioning and reduced quality of life" and he expressed hope that the study might encourage future research to increase "understanding of dopamine's role in OCD."

Lorin Koran, M.D., M.S., is an Emeritus (Active) Professor in the Department of Psychiatry and Behavioral Sciences of the Stanford University Medical Center and Director of the Stanford OCD Clinic. Review committee member James McCracken, M.D., not only praised the design of Dr. Koran's study but also the accomplishments of the Stanford OCD Program.

Yijun Liu, Ph.D., University of Florida, Gainesville, FL

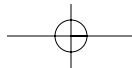
Diffusion Tensor Imaging of OCD

Dr. Liu's study intends to utilize new ways of imaging techniques to gain more information about the brain function and its relationship to OCD. Although MRIs (magnetic resonance imagings) have been used to take high quality pictures of the brain, diffusion tensor imaging (DTI) helps to visualize the brain's white matter, which may help to further understand the circuitry of the brain as it relates to OCD. A specific goal of Liu's research is to "yield new information regarding white matter abnormalities in OCD." SAB Review Committee member Benjamin D. Greenberg, M.D., Ph.D., is encouraged by Liu's study and finds the use of DTI "a highly promising method for understanding brain circuitry, particularly in OCD."

Yijun Liu, Ph.D., is an assistant professor of psychiatry and neuroscience in the Department of Psychiatry and the Evelyn F. and William L. McKnight Brain Institute at the University of Florida in Gainesville, FL. In recommending Dr. Liu's study for funding, Dr. Greenberg stated that he was hopeful that the study's "results may realistically find application in research and in treatment not only in OCD, but in related disorders as well."

S. Evelyn Stewart, M.D., Massachusetts General Hospital and Harvard Medical School, Boston, MA

Obsessive-Compulsive Disorder and Tourette Syndrome: Phenotype/Genotype



(TS). In her proposal, Stewart states that previous studies revealed that OCD and TS may share genetic characteristics. While these characteristic genes may be associated with OCD and TS, the genes may not cause OCD and TS. One of Stewart's goals is to distinguish "the genetic relationships between OCD and TS by searching for genes that play a role in their etiology and by examining" symptoms that might be inherited. The search for genetic clues can play a major role in diagnosis and treatment.

Dr. Stewart is an Instructor of Psychiatry at Harvard Medical School and is a member of the Psychiatric and Neurodevelopmental Genetics Unit in the Center for Human Genetic Research at Massachusetts General Hospital, a clinical researcher with the Richard B. Simches Research Center, and an attending physician at the MGH Obsessive-Compulsive Disorders Clinic and at the MGH Pediatric OCD/Tourette's Disorder Clinic. Review Committee member Dr. David Rosenberg of Wayne State University writes that Dr. Stewart's research represents "an exciting study in an understudied area and can potentially better define the clinical endophenotype of OCD and TS."

**Emanuel Voyiaziakis, M.D., M.S.,
Research Foundation for Mental
Hygiene, New York State Psychiatric
Division, New York, NY**

*Candidate Gene Study of Obsessive
Compulsive Disorder in a U.S. Sample*

Dr. Voyiaziakis will conduct a study of more than 200 families to identify candidate genes associated with OCD. So far, almost a dozen candidate genes have been identified. Dr. Voyiaziakis will utilize technological databases that are designed to identify and record genes related to particular diseases. The OCD Collaborative Genetics Study (OCGS), which is a collaborative project of six institutions, will add critical information to the current study. In his research proposal, Dr. Voyiaziakis states that "OCGS sample is the largest known genetic sample for the study of OCD."

Dr. Voyiaziakis is a post-doctoral research fellow at the Research Foundation for Mental Hygiene of the New York State Psychiatric Institute. Review Committee member, Dr. Margaret Rickter, writes that Dr. Voyiaziakis submitted "...a straightforward proposal that should be successful in furthering understanding of susceptibility genes for OCD." Review Committee mem-

On The Air and (Soon) Out In The Open

By Jeff Bell

For nearly a decade now, I have had the privilege of spending a few hours every weekday with untold legions of Northern Californians. I've awoken them in the morning, driven with them to and from work, and kept them company during bike rides, workouts, and the like. I have shared slices of my own life with them, and have tried to be a reliable, trustworthy friend. I haven't actually met the vast majority of these folks, but thanks to the magic of modern electronics, I'm guessing a good many of them feel like they know me.

The thing is, they don't. Nor do most of the people who make up my world. My name is Jeff Bell, and I'm a longtime anchor of San Francisco and Sacramento radio news programs. I am also an obsessive-compulsive. And this, you should know, is the first time I've ever acknowledged that in any public way. I need to get used to it. In the near future, my story—the one I spent years trying to keep tightly under wraps—is going to be in bookstores everywhere, right there for any listener, or anyone else, to pick up and read. Yikes! What was I thinking when I decided to put down on paper all the sordid details of my elaborate double life? It's a question I still ask myself daily, and one the OC Foundation has asked me to take a stab at answering here. Honestly, I'm not sure that I can; but I'm more than willing to give it a try.

First some background. In the vernacular of our OCD world, I am a checker and washer with serious harm obsessions. My earliest memories are of OCD checking, but it wasn't until my late twenties that the full fury of the disorder kicked in for me. It was 1992, and my radio career was beginning to skyrocket. Unfortunately, so too was the time I spent consumed by obsessions and the endless checking drills that they spawned. I knew something was wrong with me, so I dragged myself to a psychologist, and then a second one. Neither of whom seemed to offer any real help. Piece by piece my world crumbled around me. And then one day in a bookstore I stumbled across a book with a strange but alluring title. *The Boy Who Couldn't Stop Washing* it was called; and on its pages, I discovered the sobering truth about who and what I am.

That book forever changed everything for me. Because of Dr. Judith Rapoport and her obsessive-compulsive patients who shared their stories, I knew my affliction had a name and treatment. I knew I'd never again feel so alone or crazy. And I knew to pick up the phone and call the OC Foundation, which, in turn, pointed me

Dr. Rapoport's collection of intimate OCD accounts saved my life. It also, I now imagine, served to plant a wild idea in the deepest recesses of my mind, one that would much later prompt me to spend a full year recording on hundreds of index cards my every obsession, compulsion, triumph, and setback, and would keep me going through seven more years of stringing together those cards into the form of a book.

The wild idea? Maybe if I put everything down on paper, I could help a few others find themselves in my story, and—perhaps quite selfishly—I could give some meaning to the many years OCD had stolen from me.

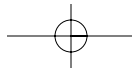
Funny, but somewhere along the way that wild idea became a plausible notion and, ultimately, a genuine reality.

There is, I suppose, something quite ironic about an obsessive-compulsive checker attempting to tackle a literary format as fraught with uncertainty as memoir. Suffice it to say that I have agonized over every fact, every memory, and every single word I have put in the book. I have played and replayed and re-replayed in my mind every scene that makes up my story. To this day, I wonder how I'll ever be able to sign off on the final manuscript. Fortunately, I'm working with an amazing editor who really "gets" my issues with this, and is gently and patiently guiding me through the process.

We in the news business sometimes opt to sit on a story, meaning we choose not to report on something because of some compelling reason. As my voice of doubt points out to me regularly, there are a thousand reasons—all of them compelling—why I should sit on my story. Over the years, however, I've come to recognize this taunting whisper as the same one that wants me to squander my life on futile checking rituals; and if there's one thing I've learned from my writing project, it's that listening to my voice of doubt never serves any greater good.

If all goes as planned, I'll be spending some time on the road next year, talking openly about my OCD and doing what I can to raise awareness about the disorder. Here's hoping I get to meet you along the way. In the meantime, if you happen to find yourself in the San Francisco Bay Area, and you happen to hear some guy on the radio named Jeff Bell giving you the news, smile and know you're one of the first on the block to know his secret.

Jeff Bell co-anchors the afternoon news at KCBS Radio in San Francisco. His book, "Rewind, Replay, Repeat: A Memoir of



Research Digest

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

This Research Digest reviews recent research on body dysmorphic disorder (BDD). Considered an OC spectrum disorder, BDD involves obsessions with an imagined or slight defect in appearance. The DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) criteria for the diagnosis of BDD are:

A. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive.

B. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in Anorexia Nervosa).

Katherine Phillips, M.D. is the recognized maven on BDD, with more than 100 papers and several books on the disorder. Her most popular book is "The Broken Mirror: Understanding and Treating Body Dysmorphic Disorder." Not surprisingly, she has authored or co-authored six of this issue's articles. Many thanks to Dr. Phillips for her contribution to our understanding of BDD and its treatment.

The prevalence of body dysmorphic disorder: a population-based survey

Psychological Medicine, Epub ahead of print, 2006, W. Rief, U. Buhlmann, S. Wilhelm et al.

In Germany, the prevalence and clinical features of BDD were studied using a nationwide survey with 2,552 participants. A substantial number of people surveyed had concerns about unattractive body parts, but only 1.7% individuals (42) were diagnosed with BDD. Individuals with BDD reported higher rates of suicidal ideation (19% versus 3% in non-BDD group). BDD was also associated with

study on prevalence of BDD in the general population.

Gender similarities and differences in 200 individuals with body dysmorphic disorder

Comprehensive Psychiatry, 47:77-87, 2006, K.A. Phillips, W. Menard and C. Fay

In this study, 63 men with BDD were compared to 137 women with BDD. There were more similarities than differences; but some interesting and important differences were found. Men were older, more likely to be single and living alone, and were more likely to have a substance abuse disorder. Men were also more likely to obsess about their genitals, body build (being too small) and thinning hair. Women were worried about more body areas than men. They were more likely to obsess about their skin, stomach, weight, breasts, buttocks, thighs, legs, hips, toes, and excessive body/facial hair. Women were also more likely to have an eating disorder. Women performed more repetitive and safety behaviors, such as checking mirrors and camouflaging the perceived defect. Gender similarities included past suicide attempts (approximately 25% of individuals), having tried cosmetic surgery (19% of individuals), and comorbidity with depression or anxiety disorders (approximately 80% and 70%, respectively).

Clinical features of body dysmorphic disorder in adolescents and adults

Psychiatry Research, 141:305-314, 2006, K.A. Phillips, E.R. Didie, W. Menard et al.

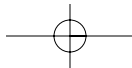
Although typically beginning in adolescence, there has been little research on BDD in this age group. This study examined BDD in 36 adolescents and compared these adolescents to 164 adults with BDD. Adolescents were obsessed with many body areas, most often their skin, hair, and stom-

ach attempted suicide. They also experienced significant impairment in school, work and other aspects of psychosocial functioning. For example, 22% had dropped out of school. Nearly half of these adolescents had received medical or surgical treatment for BDD. Additionally, they reported that a substantial number of their mental health providers were unaware of their body image concerns. Adolescents and adults were similar on most aspects including a preponderance of female BDD sufferers, although adolescents had more delusional BDD beliefs and a higher rate of suicide attempts.

Delusional versus nondelusional body dysmorphic disorder: clinical features and course of illness

Journal of Psychiatric Research, 40:95-104, 2006, K.A. Phillips, W. Menard, M.E. Pagano et al.

BDD is classified as delusional or nondelusional. Delusional BDD refers to those patients who firmly believe they have an actual physical deformity when they do not. The DSM-IV classifies these subgroups separately. BDD is classified as a somatoform disorder and its delusional variant is classified as a psychotic disorder. Researchers compare these disorders in a group of 191 individuals with BDD, 68 delusional patients and 123 nondelusional patients. Groups were similar in most respects, including a similar likelihood of responding to treatment based on a one-year follow-up. There were differences that included delusional patients having significantly lower educational attainment, poorer social functioning, a higher incidence of substance abuse, more severe BDD symptoms, more likely to have attempted suicide and less likely to have received mental health treatment in the past. However, when controlling for BDD symptom severity, the two groups differed only in terms of educational attainment. Based on these findings, the classification of BDD is discussed with



Comorbidity of body dysmorphic disorder and eating disorders: severity of psychopathology and body image disturbance

International Journal of Eating Disorders, 39:11-19, 2006, J.S. Ruffolo, K.A. Phillips, W. Menard et al.

The co-occurrence (comorbidity) and clinical effects of eating disorders in a large sample of individuals with BDD were examined. A high number (32.5%) of the 200 individuals assessed had a lifetime history of an eating disorder with 15% having a current eating disorder. A comparison was made between individuals with a comorbid lifetime eating disorder (n=65) and individuals without an eating disorder (n=135). Individuals with both disorders, eating disorder and BDD, were more likely to be female, less likely to be African American, had more comorbidity with other disorders, and had significantly greater body image disturbance and dissatisfaction. Additionally, the group with both disorders had received a greater number of psychotherapy sessions, psychotropic medications and hospitalizations for psychiatric problems.

Body dysmorphic disorder and social phobia: cross-sectional and prospective data

Depression and Anxiety, 23:26-33, 2006, M.E.Coles, K.A. Phillips, W. Menard et al.

The relationship between BDD and social phobia (SP) was examined, looking at the occurrence and clinical effects of the comorbidity. Of 178 individuals with BDD, approximately one-third suffered SP. These 70 individuals with both disorders were compared to the 108 individuals with BDD without SP. The onset of SP was typically before the onset of BDD. Individuals with both disorders were significantly less likely to be employed, were more likely to report suicidal thoughts, and had poorer social adjustment. The groups were similar in many ways, including a preponderance of female gender, age of BDD onset, severity of BDD, and overall functional disability. Both groups reported elevated social anxiety, with individuals suffering both BDD and SP experiencing additional social anxiety that appeared

year follow-up, patients with both BDD and SP were somewhat less likely to respond to treatment of their BDD symptoms, although the difference was not statistically significant. Researchers discuss the classification of BDD. Based on high comorbidity and disease similarities, they suggest consideration of BDD as a social phobia spectrum disorder. In Japan, SP is diagnosed as taijin kyofushu, a disorder having four subtypes. One subtype is shubokyofu that is defined as "the phobia of a deformed body" and is similar to BDD.

A meta-analysis of psychological and pharmacological treatments for body dysmorphic disorder

Behaviour Research and Therapy, 44:99-111, 2006, J. Williams, T. Hadjistavropoulos and D. Sharpe

Meta-analysis is a mathematical process of combining and comparing research results from previous separate but related studies. Fifteen BDD treatment studies, 6 drug therapy and 9 behavioral or cognitive-behavioral therapy were identified and evaluated. Findings supported the effectiveness of both types of therapy, but suggest that cognitive-behavioral treatment may be the most useful. Depression is commonly comorbid with BDD and findings indicated that BDD and depression symptoms improved with treatment. Many patients who received behavioral therapy were also on medications, but data from the studies analyzed could not determine the impact of combining these treatments.

An open-label study of escitalopram in body dysmorphic disorder

International Clinical Psychopharmacology, 21:177-179, 2006, K.A. Phillips

Selective serotonin reuptake inhibitors (SSRIs) are first-line medications for the treatment of BDD. Escitalopram (Lexapro) is an SSRI that has not been studied for BDD. In this small study, 15 subjects with BDD were treated with escitalopram. BDD symptoms significantly improved with 73.3% (11 patients) responding. Depressive symptoms, delusions and overall functioning also significantly improved. These preliminary findings suggest that escitalopram

New Parents Guide Available from OCF Chicago

OCF Chicago's new publication, "How to Help Your Child: A Parent's Guide to OCD"

addresses the concerns of parents who believe their children may have Obsessive Compulsive Disorder, or whose children have been diagnosed with OCD. The attractive, 24-page guide describes symptoms, diagnosis, and appropriate treatment for OCD and discusses how the disorder impacts families and schools. The guide answers frequently asked questions and provides a list of recommended books for further information.

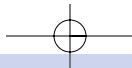


The Parent's Guide is the result of an extensive collaboration at the Obsessive Compulsive Foundation of Metropolitan Chicago (OCF Chicago) that involved volunteers from a wide variety of backgrounds, including parents of children with OCD and members of the OCF Chicago Scientific Advisory Board with expertise in treatment and educational accommodations.

The guide is presented in warm, appealing colors and illustrated with photographs of children and families. "Many of the parents who call for information about OCD are in crisis," explains Ellen Sawyer, executive director of OCF Chicago. "This publication provides information they need to get help for their children, and it's designed to be accessible and reassuring."

The Parent's Guide touches on the topics of immediate concern to parents, with emphasis on where to turn for help. "The guide is meant to be a great place to get started," said OCF Chicago board member Lisa Gallo Hayes. "It directs parents to the treatment providers and books that can help the family learn how to respond to and manage OCD."

"How to Help Your Child: A Parent's Guide to OCD" is available as a PDF download at the OCF Chicago web site, www.ocfchicago.org. The OCF Chicago brochure for teens and pre-teens, "Got OCD?" is also available as a PDF on the web site. Individuals who do not have Internet access may obtain copies of the parent's guide and teen brochure by contacting OCF Chicago at (773) 880-1635 (or email info@ocfchicago.org) and providing their full mailing address.



NEW PROGRAM FOR CHILDREN AND ADOLESCENTS

The following is an interview with Andrew Gilbert, M.D., about the Obsessive-Compulsive Disorder Intensive Outpatient Program at the Western Psychiatric Institute and Clinic.

NEWS LETTER: While Western Psychiatric Institute and Clinic has had an intensive treatment program for adults for a long while now, when did you open your Intensive Outpatient Program (IOP) for children and adolescents?

GILBERT: On July 11, 2005.

NEWSLETTER: What made Western Psych feel it needed to open an intensive treatment program for children and adolescents?

GILBERT: Western Psychiatric Institute and Clinic (WPIC) recognized a pressing need in the Western Pennsylvania region for a specialized treatment center for children and adolescents with OCD.

NEWSLETTER: Can you describe the IOP to our readers? Is it similar to other plans for children and adolescents? What is unique about it?

GILBERT: The WPIC Child and Adolescent Obsessive-Compulsive Disorder Intensive Outpatient Program (OCD-IOP) specializes in the treatment of children and adolescents with OCD. The clinic is part of the WPIC Child and Adolescent Partial and Intensive Outpatient Programs. We are located in the Southside neighborhood of Pittsburgh, PA. We are unique in that we are the only specialized pediatric OCD program in the region and one of only a few in the country. We provide specialized and individualized treatment for each patient based on his/her personal needs. Our program is similar to other programs in that we practice evidenced-based treatment, which includes cognitive-behavioral therapy (CBT) with exposure and response prevention (ERP), pharmacotherapy, and family therapy.

NEWSLETTER: Is this service going to be devoted to the treatment of OCD or will children with other anxiety disorders be in the program?

GILBERT: At the time our treatment protocol is for children and adolescents with a primary diagnosis of OCD. However, we provide treatment for other anxiety and/or mood disorders within the WPIC Child and Adolescent Partial/Intensive Outpatient (IOP) Programs

NEWSLETTER: What age range do you treat at the IOP?

NEWSLETTER: What treatments for OCD are used in your program?

GILBERT: The IOP provides a comprehensive diagnostic evaluation, psychoeducation for patients and families, family therapy, individual therapy, and medication management as indicated. CBT emphasizing ERP is provided in a group format and also individually as indicated.

NEWSLETTER: What is the daily treatment regime for a child or teenager in your program? Are the regimes similar for children and adolescents?

GILBERT: The daily treatment regimes are similar for both children and adolescents. However, there is flexibility in that each regimen is adapted to the individual needs of the patient. The daily schedule consists of the following in chronological order: homework check-in, group and individual exposures, free-time in the gym and socialization with peers, another block of exposures, final group wrap-up, check-in and assignment for the evening. As the child psychiatrist in the group, I will conduct patient rounds twice a week, during which time I will meet with each child/adolescent and parent to review progress and assess the need for medication. If a child or adolescent is taking medication, I review effectiveness and make changes as indicated.

NEWSLETTER: Why have you set up a program that is based on medication and cognitive behavior therapy? Are these treatments what are known as "evidence-based treatments"?

GILBERT: Consistent with the overarching mission of WPIC, we practice evidence-based treatment. Currently, treatment studies of children and adolescents with OCD support the use of CB/ERP or pharmacotherapy, or a combination of the two. Every child/adolescent is evaluated and an individual treatment plan is developed. Although all of the kids will receive psychotherapy, some will receive psychotherapy alone, while others will receive a combination.

NEWSLETTER: Do you or someone on your staff do a preliminary consultation with a potential patient and/or parent who wants his child to be in your program? Who does the diagnosing? Are co-morbid disorders diagnosed at this time?

GILBERT: The initial contact with the family is done through a phone referral conducted by the intake clinician to gather pre-

liminary information. After the completion of the evaluation, the clinician will discuss all formulated diagnoses as well as treatment recommendations with the patient and the family. The case is also reviewed by the treatment team, which includes the child psychiatrist, therapists, social workers, and nurses. If our program is not indicated, the clinician will assist the family in exploring other treatment options. Throughout a child/adolescent's stay in the program, the treatment team conducts weekly meetings that involve a review of each case.

NEWSLETTER: Why is your program "intensive"? How does it differ from non-intensive programs?

GILBERT: Children and adolescents attend the program for nine hours per week. This differs from traditional outpatient therapy, which typically meets approximately one hour per week. The program dates and hours are as follows: Monday, Tuesday, Thursday and Friday for two hours and fifteen minutes per day. The average length of stay is approximately twelve to fourteen weeks.

NEWSLETTER: Can you describe for our readers the "typical" first day of the program?

GILBERT: There is really no "typical" first day because it depends upon each individual patient. Some patients will quickly connect with the environment and are ready to "jump right in" and meet the other kids and attend group. Others, of course, may feel less comfortable with the environment and may take longer to get into it.

NEWSLETTER: Does a child have to leave school for the duration of the treatment? Is there any interaction between the individuals doing the treatment and the child's school?

GILBERT: Children do not have to leave school for the duration of the treatment. The program hours are scheduled after school. However, sometimes accommodations are made for children to leave school early if necessary. Contact with the children's schools is carried out on a case-by-case basis with consent from the parents. A school liaison is assigned to contact the school and set up school meetings to discuss appropriate individualized accommodations. Program clinicians will also be available at times to meet with and provide psychoeducation to schools when necessary and at the



ENTS AT WESTERN PSYCHIATRIC INSTITUTE

continue in it until his/her OCD is completely manageable?

GILBERT: If it is clinically necessary for the child to be treated at this level of care, we will continue to treat him/her. When the family and treatment team feel as though symptoms can be managed on a less intensive basis, we develop a disposition plan.

NEWSLETTER: Please outline the first week of treatment in the program. What do the patients do? What do their families do? How are they initiated into the program?

GILBERT: During the first week of treatment, patients meet individually with a clinician for psychoeducation and "treatment readiness." We use the "Up and Down the Worry Hill" treatment protocol throughout the treatment process. This program was taught to our staff by the author, Aureen Pinto Wagner, Ph.D., a specialist in the treatment of pediatric OCD. "Treatment readiness" is just what it sounds like – it involves preparing patients for treatment and assessing whether they are "ready."

This first week involves encouraging kids to externalize and label their OCD. Often children become very creative and draw elaborate pictures of what their OCD looks like to them, helping them to externalize the problem. We also encourage the kids to begin to recognize and verbalize the problem and to recognize and verbalize their fear, and we have the children rate each fear on "The Worry Hill Feelings Thermometer." Using the "Feelings Thermometer," the child and therapist develop a hierarchy of OCD behaviors which we call the "Fear Ladder." Parents are encouraged to participate in this process by providing support and feedback to their child during the development of the "Fear Ladder."

Often parents provide clinicians with a detailed list of the child's fears, some of which the child may not be aware of. The therapist also takes time to provide more education about obsessions, compulsion, exposures and response prevention. It is vital to gain a child's trust in order to help him/her to begin tackling the OCD. Once the child has demonstrated knowledge of exposures, s/he is introduced to the group. The therapist and child then collaborate on their first exposure. As a general rule, we encourage the child to start with an exposure that has rated no higher than two on

NEWSLETTER: Does a child have to be on or off medication to enter the program?

GILBERT: It doesn't matter. Some kids are taking meds, others are not. There are no formal rules regarding medication status for participation in the program.

NEWSLETTER: What are the qualifications for a patient to be admitted to this program? Does he/she have to have been treatment resistant?

GILBERT: In order to be admitted to this program, patients need to have a primary diagnosis of OCD and their symptoms need to be at a level of severity that has not or will not respond to traditional outpatient treatment. Treatment resistance is not a requirement.

NEWSLETTER: When do you start a patient on medication? How do you decide which medications to use?

GILBERT: The decision to start patients on medication is made by the patient and his/her family, with education and support coming from the treatment team. Each case is unique so there is no rigid protocol regarding the decision to use medication. Medication is generally considered when psychotherapy has not been effective enough to reduce the severity and frequency of the symptoms. Because of the high rates of comorbid psychiatric disorders in pediatric patients with OCD, we are also frequently treating other disorders, such as, tic disorders, ADHD, depression and other anxiety disorders, with medication. Many children will come into the program with several diagnoses, including OCD and are already receiving pharmacotherapy.

NEWSLETTER: Can a patient be admitted if s/he has never done CBT? What if s/he's failed at CBT?

GILBERT: Prior treatment with CBT is not a requirement for admission to our program. If a child or adolescent has had previous experience with CBT and has struggled, we adapt the protocol to the individual patient.

NEWSLETTER: How is CBT done with a patient? Does s/he have a designated therapist who will do the CBT and ERP with him daily?

GILBERT: While each patient has an assigned primary therapist and family social worker, we use a very "team oriented" approach to treatment; several staff members work with all of the kids. We find that having a variety of different staff

NEWSLETTER: How is a team selected for a patient?

GILBERT: To begin with, the treatment team incorporates a combination of patients into groups based upon personality styles and our predictions as to which children might have positive interactions with and influences upon each other. When we first started, we attempted to group patients by age with older and younger groups. But we have discovered that a combination of different ages and abilities works very well and has encouraged positive peer interactions and peer support. We run two groups per treatment day. Families can certainly voice a preference for which group time will be more convenient for them.

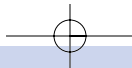
NEWSLETTER: Are the patient's parents trained to work with their child as therapy coaches? Are they educated about how to help an individual with OCD without enabling the person? Do parents have a chance to meet with other parents during their child's treatment? Are there support groups for the parents?

GILBERT: Parent coaching/training is a big part of the program. During weekly family sessions, parents receive training in how to support their children using ERP at home. We discuss issues such as enabling and how to gradually separate themselves and the family from their child's rituals. Our parents tend to stay in the building while their children attend the program. This provides an opportunity for parents to network with each other in an informal setting. Parents frequently report that this has been helpful for them. We are also working towards the development of more structured parent support groups in the community.

NEWSLETTER: Does your program try to educate a child's teachers about his/her OCD. Are they given any training in acting as the child's behavior coach when it is appropriate during the school day?

GILBERT: With parental consent, we will communicate with school personnel (teachers, guidance counselors, principals/vic principals) and provide education about OCD and how it may be affecting the individual child's academic performance both at school and at home. While we will offer in-services for school personnel about OCD, we do not train individual teachers as behavior coaches.

NEWSLETTER: Do you have residential



TWO PERSPECTI

What's Their Role In The OCD Family

*By Constantina Boudouvas, LCSW
Houston, TX*

Siblings of persons who are diagnosed with OCD vary in their response to OCD as much as the persons with the disorder vary in their response to anxiety and to treatment. I do not think that Alexis (see the following article) or I hope to write an all-inclusive article about the impact of OCD on siblings and pretend that we know all of the facts, breadth or depth of experiences. What I believe we would like to do is raise awareness and also share with you our unique experiences with this topic and allow for the opportunity for a dialogue to begin about it.

Alexis and I first met at the OCF Annual Conference in Nashville, Tennessee. After my presentation on the impact of OCD on families, Alexis, moderator at the presentation, bravely stood up and asked me about my thoughts on the impact of OCD on siblings. I realized that what I'd been remiss in doing is involving a perspective from and about siblings in my presentation. Although I have made it a practice to involve siblings in my family meetings and therapy when working as a behavior therapist with patients at the Menninger OCD program, I had not raised this important issue at the Conference. I realized that my presentation mirrored what happens in families in that my focus had been on the intense accommodation and relationships that occur between parents and the child with OCD and neglected to bring into the context how OCD impacts siblings.

Being one of five siblings in a family that has had its own share of emotional problems, I am keenly aware of the impact that family members have on each other and on symptom development, maintenance and recovery. I believe that a child's sensitivity to other members in the family is a key variable in how they will respond to the person who has OCD as well as to the family focus that usually occurs. I dare say that some siblings, free from being scrutinized by parents, at times do develop more independent living skills and learn how to problem-

solve a cost with respect to feeling that they did not have the same emotional support and/or availability from parents as their sibling whose symptoms demanded so much time and attention from parents. Although they may become more self-sufficient and independent, they often times talk about a sense of loss, and sometimes anger and resentment because they felt that they could not go to their parents with problems that seemed unimportant and small compared to the crises that sometimes or often occur with their sibling.

Siblings may also respond to the person with OCD with significant anger and hostility, mimicking their rituals or provoking them by triggering them in a very sarcastic and hostile manner. In this situation, I believe that it is important to educate them about OCD and to also begin to help them express their own anger/frustration about what it's like to live with OCD, especially if OCD rules are ruling the roost. Parents will have to discern (easier said than done) how to handle this type of teasing, differentiate normal sibling conflict/rivalry from behavior that is hostile and provoking, and get coaching on when to confront it and when to let it go.

Some siblings have also shared their experiences of feeling as if they need and want to protect their parents from the sibling with OCD. Often times they express frustration and anger at being powerless to change their sibling's and or their parents' response to the OCD symptoms.

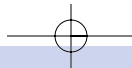
Siblings may also respond with anger at one or both parents at not doing "more" to help their brother or sister. In some ways, they may also feel that parents are neglecting their own need to be protected from the impact of OCD. Being able to share openly as a family about the sense of powerlessness that comes in living and loving someone who has OCD can have a profound impact on an individual's ability to problem-solve and cope with the impact of this disorder on their lives.

I have found it helpful to allow siblings to

ing in an inpatient setting, I found it critical to coach parents and talk with siblings about beginning to stop their accommodating behavior. I explain to them why their family culture/rules may have been hijacked by OCD rules. If friends have not been allowed to come into the home in order to accommodate a sibling's triggers around contamination obsessions, I will work with the family and client to create a safe zone that does not involve community areas. This communicates to the sibling that although there may be a transition period, because treatment and progress do take time, they no longer have to accommodate the OCD to the extent and degree that they may have been doing. Again, it is important to do this with the help of a behavior therapist who can communicate to the person with OCD what the timeline and plan for withdrawal of accommodations are. The therapist can also empower the family to begin to create a culture of change in their household.

One of the most valuable interventions that parents can bring about is to begin to shift back to normal family routines and create a culture of change in their household. One of the themes that we often use with the adolescent and adult patient communities at the Menninger OCD program involves encouraging patients to support each other in creating a culture of change. This would involve not accommodating each other's symptoms and helping to minimize the influence that OCD had in the living community that they all shared while patients there.

I've often found that having siblings involved in treatment provides me as therapist with a unique perspective and insight into what is going on in the home environment. Many times, siblings can be the "voice of reason" maintaining perspective when parents, due to their exhaustion and own anxiety, have become too entangled in symptom accommodation to change their behaviors. When siblings are old enough, I may involve them in exposure ritual prevention. This allows for the family to



ES ON SIBLINGS

A Sibling's Point-of-View on OCD

By Alexis Kant

My name is Alexis and it has been almost twelve years since OCD entered my family's life. You may know my mom, Joy Kant, the President of the OCF Board of Directors. She became involved with the OCF shortly after my brother Jared was diagnosed. For the past few years, my entire family has pitched in at the OCF Annual Conference, and that is how I met Constantina.

As Constantina mentioned, siblings in families of OCD sufferers often get overlooked, because those who have OCD and their parents tend to require more attention. Our hope in writing these pieces is to shed some light on siblings' experience with OCD. With that in mind, I would like to share with you some details of my own story.

When I was 14, my little brother, then 11, was diagnosed with OCD. I think the best way to explain how it impacted my family is to say it hit us like a Mack truck.

One of the most poignant memories I have of this time is sitting at the kitchen table with my mom. My father was away on a business trip and my brother's OCD had hit an all-time low. After a particularly difficult night, he had finally retired to his room. I remember looking at my mom, tears streaming down my face, and saying, "I just don't understand. It's not fair! I mean - why did it have to be him?"

It's a question I've never been able to answer.

My mom gazed at me for a second and then started to cry herself. For the first time since he was diagnosed with OCD, my mom and I finally began to divulge our inner frustra-

aloud before this moment. We had just never said them to each other. At one point, we started cursing OCD, causing us to laugh. My mom and I hated this illness and everything it was doing to my brother.

It's not exactly the thing that every daughter dreams of bonding over with their mom. But I finally felt like I was in on everything. It was the first time that both of us really let down our guard and showed each other how we felt. Like my parents, I wanted to protect my brother. And being unable to do that, I felt powerless too. But since I wasn't the parent and they didn't want me to have to share the responsibility of being one, I was often left out of the more serious matters. Still, as much as my parents tried to shield me from the bitter truth, there was no denying that something was horribly wrong in our house during those days. It was my freshman year of high school and I spent most of my time burying my nose in my textbooks and doing my best to keep the family "secret" in order to respect my brother's privacy.

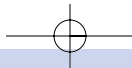
My parents did their best to pay attention to both of us, but my brother's needs demanded more of their time. At first, I did everything I could to be a good kid - kept up with my schoolwork, took on more responsibilities - because that way they would have less to worry about. I stopped going to them for "little" problems like a fight with a friend because I didn't want to bother them. (It wasn't until years later in our first siblings workshop that I finally realized they would have appreciated those moments because they actually knew how to handle them!)

By junior year, I started to give up. I

school because of his OCD, then I didn't want to outshine him. As for the family secret, I now had that down to a science. The car ride to and from school became my therapeutic outlet - ten minutes to let my tears flow and listen to sad music before a quick wipe of the eyes. I had a few close friends that had an idea of what I was dealing with at home, but nobody really understood and talking about it often made people uncomfortable.

It wasn't long after my grades started slipping that my parents knew I was having a hard time with everything. My mom was adamant that while we had done some family counseling, I needed to start seeing a therapist on my own. To say that I was hesitant about going is putting it mildly. I just didn't see how this therapist could make it all better - if she couldn't make the OCD go away, then what was the point? It wasn't long into my first session that I realized I wanted to talk to this woman for hours on end. I was finally able to say how I felt about all of it - the illness, my frustration, how my family was handling it. And the fact that this person wasn't connected to my family meant that I could be really honest and I wouldn't run the risk of hurting anyone's feelings.

As I sit here today about to start a doctoral program in clinical psychology, I know that sending me to a therapist was one of the best decisions my parents ever made. Every member of the family is affected by OCD and therefore deserves support. I hope that this piece has offered some insight into one sibling's experience, and I urge all siblings to stop by our siblings session at the upcoming conference. You don't have to talk: listeners are wel-



Intensive Treatment Program Behavior Therapy Center

Dr. Paul Munford answers questions in this interview about the Cognitive Behavior Therapy Center for OCD and Anxiety in San Raphael, CA.

NEWSLETTER: Can you describe your Intensive Treatment Program for OCD at the Cognitive Behavior Therapy Center for OCD and Anxiety?

MUNFORD: Our Intensive Treatment Program is designed for people with OCD who need hands-on assistance from experts to do the therapeutic work. The program operates from 9 am to 1 pm, Mondays through Fridays, with the total number of days determined by the needs of the particular client. However, most people spend four to six weeks with us and leave the program able to participate in school, work, volunteering, family and social activities without the limitations imposed by OCD. No more than four clients are enrolled at any one time.

The Intensive Treatment Program takes place in a comfortable office suite with beautiful views of the San Rafael Mission. Our location offers a variety of opportunities for exposure and response prevention exercises that are not available in hospitals or clinics. People can practice everyday activities that have been blocked by OCD. For example, those with contamination worries can learn to manage them by practicing activities that they have feared such as showering, vacuuming, dusting and so forth. These and similar exercises can also help those who are overly responsible or perfectionist learn to accept mistakes and set reasonable performance standards for themselves. Our setting also makes it easier for the clients to transfer skills learned in the program to their homes. We think you will find the ambience to be beautiful and peaceful.

NEWSLETTER: What treatment modalities do you employ in your Intensive Treatment Program? Do you use exposure and response prevention therapy, psychopharmacology and any other treatment techniques?

MUNFORD: Yes, we employ exposure and response prevention therapy used either separately or in combination with medications. Our treatment plans are tailored to the particular needs of the individual, so this could mean a combination of techniques including exposure and response preven-

tion, and stress management.

NEWSLETTER: What is the philosophy behind your Intensive Treatment Program?

MUNFORD: OCD is a disorder of fear — fear that is inappropriate and excessive. When the fear is eliminated, so are the obsessions and compulsions. We believe that the best way to eliminate fear is for people to learn how to face it. So, using proven methods, we teach clients how to face, embrace, and erase the fear. This is done with patience, compassion, and friendly persuasion. When they feel the fear fading, they become inspired to defeat it and take charge of their lives.

NEWSLETTER: How effective is your Intensive Treatment Program?

MUNFORD: We used the Yale Brown Obsessive-Compulsive Scale (Y-BOCS) to measure the effectiveness of our treatment program by comparing the severity of 46 OCD patients' symptoms before treatment and at the end of treatment, which generally took four weeks. The average score before treatment was 27, which indicates their symptoms were severe. After treatment, their average score was 15, which indicates their symptoms were mild. This change means that, on the average, there was a 47% improvement in their symptoms — progress enough to allow them to function normally while continuing weekly outpatient treatment.

NEWSLETTER: Patients in your program play an integral part in each other's treatment. Can you explain how that works?

MUNFORD: An important way in which we learn new behaviors is by imitating the behavior of others, particularly when the behavior is successful. This occurs in our program when people who have progressed in treatment help those who are just starting by modeling the correct practice of the therapeutic techniques. As a result, these beginners progress more rapidly and soon become models themselves for new clients.

In addition, clients can form supportive relationships that continue after they leave the program.

NEWSLETTER: What type of person with OCD should consider enrolling in your Intensive Treatment Program?

tried outpatient therapy with no success, or they may live in communities where no effective therapy is available. We also accept people with OCD who have other conditions as well. For example, we have successfully treated OCD in combination with Asperger's Syndrome, Social Phobia, Eating Disorders, Body Dysmorphic Disorder, and Depression. We also welcome people with obsessions only.

NEWSLETTER: Do you treat children and adolescents in your program or just adults?

MUNFORD: Generally, we treat children on an outpatient basis. Most people in our Intensive Treatment Program have been 18 years of age and older. A few participants have been younger when we feel that they could benefit from our program while not distracting others from achieving their therapeutic goals.

NEWSLETTER: Do you have a set duration for your Intensive Treatment Program or does the length vary with the individual case?

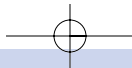
MUNFORD: There is no set duration for our Intensive Treatment Program. The length varies with each individual case. However, most people spend four to six weeks with us. Some stay for shorter periods.

NEWSLETTER: How do you determine how long a person with OCD will stay in the Program?

MUNFORD: This determination is made in collaboration with the person. Treatment progress is periodically assessed with the Yale-Brown Obsessive Compulsive Scale, the Brief Symptom Inventory, and the Target Complaint Scale. This, along with observations of staff and, when appropriate, the client's significant other, helps us decide when the person can leave the program and complete recovery with outpatient treatment.

NEWSLETTER: What happens on the first day of your Program?

MUNFORD: The first day is spent familiarizing the client with the program and getting to know the staff. We also begin our initial assessment by having the client complete questionnaires that survey his/her OCD and provide information on his/her personal history and overall psychological health. We review the general operation of the program



Program for OCD at the Cognitive Behavioral Center Program for OCD and Anxiety

collaboratively outline treatment goals. With this information, we define our first treatment objectives.

NEWSLETTER: What's included in a typical day in your program?

MUNFORD: A typical day begins with a group meeting to discuss the clients' previous day's homework and set objectives for the present day. After this, clients work individually with staff for approximately three hours doing supervised exposure and response prevention therapy. During this period, individual and family consultation are also provided for individual issues. The day ends with another group meeting for sharing achievements and homework assignments.

NEWSLETTER: Your program is a day program. Do you have facilities for anyone who does not live within commuting distance?

MUNFORD: We do not have facilities for those who do not live within commuting distance. However, affordable lodging is available nearby. We have a list of inns and hotels that we can provide to anyone who wishes it.

NEWSLETTER: What is your patient-to-staff ratio?

MUNFORD: Depending on the number of clients in the program at any one time, the patient-to-staff ratio varies from a one-to-one patient-staff ratio to a two-to-four patient-staff ratio. We limit the total number of patients to four so we can provide this low patient-to-staff ratio.

NEWSLETTER: Some consider OCD to be a chronic illness. What kind of relapse prevention program is there at the Center?

MUNFORD: Prior to completing the program, clients are provided with specific recommendations for preventing relapse. In addition, ongoing outpatient appointments are scheduled for those living within commuting distance of our office. Telephone follow-up consultations are scheduled for others who do not live locally, or they are referred to qualified mental health professionals in their communities. If these therapists have no or limited experience with cognitive behavior therapy for OCD, we are willing to provide telephone consultation to

MUNFORD: Family members and significant others are involved in the treatment program to an extent that does not violate the client's confidentiality. With the client's consent, we find it helpful to teach family members and others how to help with homework assignments. We also find it quite important to work with clients and their helpers to eliminate any practices that maintain OCD symptoms such as enabling the client to avoid exposures exercises or assisting them with rituals. And we provide counseling to resolve interpersonal problems that impede recovery.

NEWSLETTER: What kind of follow-up treatment do you provide for your patients?

MUNFORD: We provide follow-up treatment on an outpatient basis for clients who can come to our office, and we make referrals to other professionals for those who live in other locales. We also provide treatment summaries and telephone follow-up to referring professionals and agencies, as well as treatment consultation when requested.

NEWSLETTER: The Center has three distinct treatment programs. Can you describe and differentiate them? How does a prospective patient determine which of these programs is most suitable?

MUNFORD: We offer three treatment programs: group treatment for those with mild to moderate OCD who can benefit from the least expensive treatment program; individual treatment for mild to severe OCD requiring one or more 45-50 minute sessions per week; and intensive day treatment for moderate to extreme OCD for those who have not responded or have no local access to outpatient therapy.

NEWSLETTER: Do you admit people on an emergency basis to your Intensive Treatment Program?

MUNFORD: We can admit people to our Intensive Treatment Program on an emergency basis provided they have medical clearance from a physician verifying that they do not need 24-hour medically supervised care.

NEWSLETTER: How do you determine who should be in an inpatient program and who should be in the Intensive

24-hour supervision for exposure and response prevention therapy to be successful or who need medical supervision for co-occurring complex psychiatric, substance abuse, and/or physical problems. Our Intensive Treatment Program is for clients without these complications who are willing and able to participate fully in it.

NEWSLETTER: Does your program involve any in-home visits if an individual has OCD rituals that are concentrated on his/her home?

MUNFORD: We offer in-home visits within driving distance of our center for eliminating rituals that are localized to the home when this is the only way to treat the disorder.

NEWSLETTER: Can individuals with co-morbid conditions or substance abuse problems be admitted to any of your OCD programs?

MUNFORD: As mentioned above, we frequently treat individuals with co-morbid psychological conditions, such as Social Phobia, Asperger's Syndrome, Eating Disorders, Habit Disorders (Trichotillomania), and Personality Disorders. We require substance abuse problems to be treated before clients enter our program.

NEWSLETTER: Are your programs covered by private insurance? Medicare? Medicaid?

MUNFORD: Most of our clients are covered by private insurance. Coverage is determined on a case-by-case basis. Medicaid does not cover our services and we do not accept Medicare.

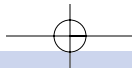
NEWSLETTER: Do you treat the Spectrum Disorders in your program?

MUNFORD: We treat hypochondriasis and body dysmorphic disorder.

NEWSLETTER: Are there any research trials at the Center?

MUNFORD: No pharmacological research trials are being conducted at the Center. However, we conduct ongoing outcome research on the effectiveness of our treatment programs.

NEWSLETTER: To enroll in a program or for more information, how do we contact you?



Famililes of OCD Sufferer's Seldom Get The Help They Need: Why They Don't and Why They Should

By Heidi J. Pollard, RN, MSN, and C. Alec Pollard, Ph.D.

*Anxiety Disorders Center, Saint Louis Behavioral Medicine Institute and Saint Louis University
St. Louis, MO*

Twelve-year-old Jill is late for a family gathering and getting more frustrated by the minute. She and her parents have been waiting in the car for half an hour while her brother checks every corner of his room to be certain nothing has been lost. She wonders, "Why does the whole family have to suffer because of him?"

Sam lost his temper this afternoon after his wife asked him the same question for the twentieth time. He's the only one who can reassure his wife that she is harmless and ease her obsessive thoughts about being a serial killer. He feels guilty about losing his temper, but is overwhelmed by his wife's constant need for reassurance.

Jack and Susan have compassion for their 29-year-old son, but their resentment and anger are growing. "If he's too disabled to help out around the house or to get a job, then why won't he seek help for his OCD?" They try to be understanding, but they know he must feel their discontent.

The truth is OCD is a family affair. The toxic tentacles of this disorder extend far beyond identified victims. Jill, Sam, Jack, and Susan all suffer from OCD although none of them has the disorder. In addition to dealing with the disruption OCD creates, family members must contend with their own emotional reactions, which can include guilt, shame, anxiety, frustration, and depression.

Research has documented the plight of those who interact with, or care about, an OCD sufferer. A majority of family members report some degree of distress adjusting to OCD (Calvacoressi et al., 1999) and for a portion the stress is significant. In one study of individuals who were the primary caregivers for an OCD sufferer, a quarter of those surveyed indicated they were "severely burdened" by the situation and "extremely distressed" at the prospect of the continued burden (Laidlaw et al., 1999).

Given the far-reaching impact of OCD, one might expect to see family members lining

ly. But this is not the case. The usual focus of family concern is squarely on the OCD sufferer. They may work diligently to find help for the OCD sufferer, but rarely do family and friends exert similar efforts for themselves.

This state of affairs is not too surprising when we examine the number of people with OCD who do not pursue professional help. If many OCD sufferers do not seek help, why would we expect other members of the family to do so? In fact, some of the obstacles that discourage OCD sufferers from seeking help are the same for family members.

There are a number of practical obstacles that make it difficult for families to get help. Some people are unable to locate a qualified provider or support network in their area, while others have difficulty paying for healthcare even if it is available. If a family member is fortunate enough to have met with a clinician familiar with OCD, the discussion is typically focused on the OCD sufferer. Many otherwise knowledgeable clinicians pay insufficient attention to the rest of the family. Too often, they underestimate the amount of support and direction needed by families who have to deal with OCD and its impact.

Families also have to contend with psychological obstacles. In a prior issue of this newsletter, we discussed how fears about the recovery process and competing incentives lead some OCD sufferers to avoid dealing with their disorder constructively. We called this failure to pursue help "recovery avoidance." Other family members may grapple with recovery avoidance as well. A husband may avoid therapy because he mistakenly believes the therapist will blame him for his wife's problems, or parents may not want to deal with the anger their son might exhibit if they seek help. An individual's assessment of the costs (e.g., danger) and benefits (e.g., incentives) of seeking help are influenced by his or her beliefs about therapy, personal control, responsibility, and other issues. Unfortunately, there are several common, but misguided notions that can discourage family members from effectively attending to their own well-being.

OCD sufferers from seeking help. There might be dozens of such myths, but in this article we focus on the six we have observed most often and the fallacies behind them. If you are stressed by the presence of OCD in your family and have not considered getting help for yourself, take a moment to see if any of these myths have influenced your behavior.

SIX FAMILY HELP-SEEKING MYTHS AND THE FALLACIES BEHIND THEM

1. The only way for my life to improve is if the person with OCD gets better.

This myth recognizes only one way your life can improve and rests your happiness completely on the behavior of another person. It will almost certainly be better for you if s/he gets better, but the progress is not in your control. What if s/he chooses not to seek help? What if s/he seeks help and doesn't participate adequately in treatment? What if his or her OCD is not treatable? These possibilities are difficult to accept. But, once you do, you can refocus your efforts on things you can do to improve the quality of your life, which is still important whether or not s/he gets better.

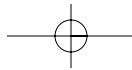
2. It's selfish to try to help myself.

This myth portrays healthy concern about yourself as something shameful. The word "selfish" is a put down, not an accurate or useful description of taking care of yourself. It implies that concern about your own well-being is inconsiderate, that it is somehow harmful to someone else. On the contrary, taking care of yourself usually helps others (see myth #3 for more on this).

3. Getting help for me will jeopardize my efforts to help the person with OCD.

This myth incorrectly suggests that helping yourself will make you less able to help the person with OCD. In fact, quite the opposite is true. When you are less burdened by frustration, guilt, and other negative emotions, you will actually be more effective in dealing with others. Can you honestly say that how you interact with the person with OCD in your current state of mind is always levelheaded and constructive?

4. The person with OCD will be upset if I seek help.



very good chance s/he will. In fact, you should be fully prepared for this outcome and plan how you will handle the expressions of anger. The problem with this myth is its two underlying assumptions: 1) that you can control whether s/he gets upset; and 2) that s/he won't get upset if you don't seek help. S/he has OCD. S/he will get upset. The choice you have is whether what you do is helpful or unhelpful.

5. I shouldn't have to be the one to change.

This myth is based on the laws of a world that doesn't exist, a world in which things are always fair. People usually use the word "should" when they don't want to deal with the real world. "Should" refers to how you feel things ought to be. But it has little to do with the world in which you live, the world about which you must make real decisions.

6. I should be able to cope without help.

There is that "should" word again. This myth refers to the make-believe world in which you are all-knowing and never need assistance from others. In the real world, reasonable people seek assistance from others who have expertise or access to resources they don't. Knowing when to seek help is not a weakness, it is a strength that improves your ability to function. Don't be the person who never reaches the destination because s/he won't ask for directions.

Left unchallenged, these myths can be quite persuasive. They are not just intellectual concepts, they are deeply held convictions tied to strong emotions. Unfortunately, that is what makes them so powerful. If myths of this nature are as common and influential as we believe they are, then it is easy to understand why so many family members neglect their own needs.

If there is someone in your life who has OCD, we hope this article has helped you sort some things out. Perhaps you have determined that the OCD in your family does not directly affect you. However, if you are one of the many family members whose lives are adversely impacted by this disorder, please consider taking active steps to improve your emotional well-being. If the OCD sufferer is in therapy, ask his or her therapist for a consultation or a referral. If not, check with clinicians in your area to see if there is someone who can work with you. See if there is a support group for family members. Explore resources on the Internet. Attend the Annual Conference of the OC Foundation. Check the Foundation's bookstore and read the books written especially for family members. Do everything you can to free yourself from the negative

The OCD Support Groups of San Diego

*By Jim Haddon, Ph.D.
San Diego, CA*

San Diego County is large and diverse, made up of many communities with a total of about 3 million people. It stretches from the Mexican border to Orange County (yes, that OC). When I started the first San Diego OCD Support Group in 1993, I was running the OCD clinical program at the University of California, San Diego. The University program was very well attended, but many people in the county either couldn't afford it or were too far away. The support group was started as a private practice mission of community outreach. I was told it was a noble effort, but that I would be hard-pressed to get many people interested without institutional backing.

Surprise! Within the first year we were averaging 10-15 attendees per night. Considering that we meet on the second and fourth Friday nights of each month, and that people had to give up a Friday night to come, this seemed pretty good. Since then, we've had as many as 35 at one meeting. Although most of our meetings are of the "open forum" variety (meaning that any OCD topics are fair game), guest speakers, videotapes, and occasional Special Topic presentations seem to draw the biggest crowds. Having these special events listed on an outgoing voicemail helps keep the community informed.

The group has always been free, and has generated drop-ins, visitors, regulars and semi-regulars. People seem to come when they need it, or when they simply want to keep up to date. Unlike some support groups, we are open to anyone that wants to come. This means that not only do OCD sufferers attend, but also family members, students and professionals. Having family members there allows us to explain to them which behaviors are truly OCD, as opposed to simply character traits of their particular OCD-suffering family member. Since group members often remark about the level of ignorance about OCD in the public and professional communities, having students and professionals attend not only allows them to learn about OCD, but it also gives the group members a chance to be front-line educators, to help in curing the disease of ignorance.

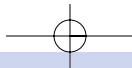
We knew we were successful when we

Yuma, Arizona and Tijuana, Mexico; so we can truly claim to be an international support group. This year we added a group in the North county coastal area on the first and third Fridays, and have tried an experiment by allowing the original San Diego group to be peer-led on one night a month. This appeals to some people who prefer to discuss their OCD issues without a "shrink" around (it also allows me to keep one Friday night a month to myself). However, having professional leadership most nights seems to be essential to continuity and decorum. Another colleague, Lori Riddle-Walker, runs another support group in the North county inland area.

Our original group has always benefited from the generous donation of meeting space in a local behavioral hospital. This sometimes creates an initial exposure for those OCD sufferers with medical or contamination fears, but even this can be reframed as a therapeutic venture. Our new North county group meets in a church, and I'm sure it creates possible exposures for our members with certain scrupulosity concerns. We often celebrate the victory of just getting to group. We make sure that everyone understands that this is not a therapy group, but rather a support group. We do not attempt to treat, but rather to educate, inform, support and encourage those that need it.

I admit that in the past 13 years there have been Friday nights I've been driving to group thinking, "I could be doing something else tonight." But I've always been glad to be there. There is clearly an interest and a need for this function, and the attendees are routinely grateful and enthusiastic. Onward!

Don't Miss
the 13th Annual OCF
Conference
July 20-23, 2006
at the
Hilton Atlanta
Atlanta, GA



From The President

Dear Friends,

First, I want to acknowledge Elizabeth McIngvale for her courage and her strength as the OCF Spokesperson for our National Public Service Campaign. Thank you, Liz, from the Board of Directors, the Staff and all who suffer with Obsessive Compulsive Disorder.



As the summer is fast approaching, I also want to remind everyone about our 13th Annual OCF Conference at the Hilton in Atlanta, Georgia on July 20 - 23. Whether or not you have OCD, we'd love to have you!

Finally, I would like to continue my introduction of the OCF Board of Directors. Aside from serving as board members, Chris Vertullo and Patricia Ballard have been vital contributors to various aspects of the conferences over the last few years.

Chris Vertullo, the Secretary of the Board since 2000, turned to the Foundation in 1993 when her daughter, Collette, self-diagnosed herself with Obsessive Compulsive Disorder soon after the stress of a car accident. Paralyzed by her OCD symptoms, Collette dropped out of college and was admitted to a hospital for treatment. It was at that time that Chris called the OCF in search of information that would help her understand the disorder, as well as a list of treatment providers.

Chris was asked to join the Board of Directors soon after the 1999 OCF Conference in Alexandria, VA. Chris is currently serving on the Executive Committee and the Education Committee. Since Chris is directly involved in teaching, she was asked to review the Foundation's "OCD in the Classroom," a program that is currently available on our website. And today, Collette, Chris Vertullo's daughter, is employed as a math teacher in classes for children with special needs.

degrees in Secondary Mathematics from SUNY New Paltz and in Computer Information Systems from Marist College. For twenty-four years Chris has served as a professor of Mathematics at Marist College. She is a member of the Teachers Education Council and the Core/Liberal Studies Committee, and she is the Director of Mathematics Placement.

Her work for the Foundation is ongoing. In 1994 she was the Founder of the OCD-L Internet Discussion Forum and moderated the List until 2001. Based on the information she obtained from the discussion forums, Chris organized six OCD Conferences at Marist College from 1996-2001. She founded the Hudson Valley OCD Support Group in 1996, which is about to reach its tenth year of service to individuals with OCD and their family members. Since 2000, Chris has presented at the national OCF annual conferences on various topics including: "How to Start An OCD Support Group," "How to Get The Most Out of the Conference," "What is the OC Foundation and How It Can Help You."

Chris Vertullo's compassion for others extends beyond those who suffer with OCD. She is a volunteer for the local Coalition for the Homeless in Dutchess County. She is very active in organizing an annual Healing Mass for the Patron Saint of Psychological and Emotional Difficulties, St. Dymphna, at a Franciscan Retreat House in Wappingers Falls. She also organizes a similar Healing Mass for the Patron Saint of Cancer. And for several years, Chris was a member of her local "Leave a Legacy" organization that encourages individuals to give to their communities by leaving a legacy to the organizations in which they believe.

Chris' life is hectic and yet she still has time to garden and enjoy her home in the Town of Clinton in New York State. She finds great comfort in the spiritual aspect of nature and in watching things grow, continuing the natural cycle of life.

It is no surprise that many of our board members have become involved with the OCF soon after their child was diagnosed with Obsessive Compulsive Disorder. Patricia Ballard is no exception.

The Foundation's website popped up and from then on, she and her husband have been grateful for the Foundation. Patti Perkins, our Executive Director, recommended books for them to read and reassured Pat and Dave that there was help for Leslie and others who suffered with OCD. Since that call, the Ballards have not only attended but also worked at the Annual OCF Conference.

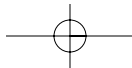
In 2001, Pat joined the OCF Board of Directors. Her undergraduate degree in Art History and American Studies from the University of Kansas has played an important role in what she has done professionally and for the Foundation. For nine years, Pat ran a business that made handwoven rugs sold through galleries in Santa Fe and Taos, New Mexico. Since then, Pat has shifted her interest to digital art. You may have seen her work at the Annual Art Show!

For the last five years, Pat has been responsible for the OCF Annual Conference Art Show that features people affected by OCD, professional and emerging artists. She is also in charge of movie night which takes place on the final evening of the conference. Last year, we watched Adrian Shergold's "Dirty Filthy Love," about a man who struggles with OCD and Tourette Syndrome. This year, we will be watching the documentary entitled "The House of the Obsessive Compulsive," which was filmed in England and features Dr. Paul Salkovskis.

Besides spending time coordinating these events, Pat Ballard is a board member of the OCF Nomination and Salary Review Committees. She has also served as the OCF's photographer in residence capturing important milestones for the Foundation. For Pat Ballard, her work for the OCF is her way of paying back all the help that was given to her family. Today her daughter attends Fordham University in New York City.

Without people like Elizabeth McIngvale, Chris Vertullo, and Pat Ballard, who willingly offer their time and themselves, the Obsessive Compulsive Foundation would not be where it is today. Pat and Chris want everyone to know that the Foundation is there to help those who have OCD and their families to find a way to live more productive, easier lives.

Best Regards,



Bulletin Board

(continued from page 2)

body (for example, your skin, hair, nose, eyes, and genitals) look? Do you think about your appearance for more than one hour per day? Do you engage in any behaviors intended to check on, hide, or fix your appearance (for example, mirror checking, comparing yourself to others, excessive grooming behaviors)? Or do you avoid any places, people or activities because of your appearance concerns (for example, do you avoid bright lights, mirrors, dating, or parties)? Do your appearance-related thoughts or behaviors cause you a lot of anxiety, sadness, or shame? Do you have problems with your work, school, family, or friends because of your appearance concerns?

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

DO YOU SUFFER FROM OBSESSIVE-COMPULSIVE DISORDER?

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

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

DO YOU HAVE OBSESSIVE-COMPULSIVE

We are conducting a research study of an investigational supplemental agent for individuals age 18-65, who have been treated for obsessive-compulsive disorder but still have symptoms.

All study-related procedures and evaluations are provided at no expense. Reimbursement for participation is available. For more information and to find out if you are eligible for this study, please call Joanna at (845) 398-2183.

The Nathan Kline Institute
Outpatient Research Program
Orangeburg, NY
www.rfmh.org/nki

UNIVERSITY OF FLORIDA RESEARCH STUDY

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

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

To be eligible, you must be at least 18 years old. If you participate in this study, you will

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

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

A FAMILY RESEARCH PROJECT

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

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

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

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

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

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

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

Your participation will help us understand family functioning in children and adolescents with OCD. Principal Investigator: Marco Grados M.D., M.P.H.

HAVE YOU BEEN DIAGNOSED WITH

OCF CONFERENCE ART CONTEST AND EXHIBIT

ATLANTA, GA

JULY 20-23, 2006

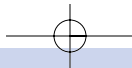
There will be money prizes for First, Second and Third Place

2006 Entry Form Available Now

Entry Form Submission Deadline:

JULY 7, 2006

Call Jeannette Cole at 203.401.2069 or email her at cole@ocfoundation.org. You can also download it from the web at www.ocfoundation.org. Limit 2 submissions.



Bulletin Board

(continued from page 17)

are diagnosed with OCD but currently not on medication for OCD treatment, you may be eligible for an fMRI research study at Mount Sinai School of Medicine. The study will involve answering questionnaires and undergoing one functional MRI (a non-invasive brain scan). You will be reimbursed for participation in the brain scan. For more information, contact Suah at (212) 241-3116.

THREE NEW PAMPHLETS NOW AVAILABLE

The OCF has recently published three brochures. One is a revised edition of "Questions & Answers about Obsessive-Compulsive Disorder." The other two pamphlets are new. They are "How Do I Know If My Therapist Can Treat OCD?" and "Questions & Answers About OCD in Children and Adolescents." If you would like to order any one or all three of these pamphlets, please contact Leslie at capezzone@ocfoundation.org.



Celebrate
The Foundation's
20th Anniversary
by Giving to
the OCF Research

Western Psychiatric

(continued from page 9)

cents at the OCD IOP.

NEWSLETTER: Do you have hotels or apartments near-by that could be used by families who are not within daily commuting distance to Western Psych? Can you help a family make these kinds of arrangements?

GILBERT: Yes, in fact there is a Holiday Inn Express directly across the street from our building. The hotel has graciously agreed to a discounted rate of \$59/night for families in treatment with us. Since we are part of a nationally known medical center, there are other available family accommodations, such as the Ronald McDonald House.

NEWSLETTER: Do you allow children with co-morbid diagnoses to participate in your IOP? What comorbid conditions would rule out the possibility of the child participating in your IOP?

GILBERT: The OCD IOP is not intended for children and adolescents with active and unstable substance abuse or dependence disorders, or for individuals with active manic or psychotic symptoms. As previously mentioned, however, many children have comorbid diagnoses, including mood disorders, other anxiety disorders, ADHD, tic disorders, Asperger's/PDD, and others.

NEWSLETTER: What kind of research is presently being done at Western Psych relative to OCD or an OC spectrum disorder? Do you enlist IOP patients in any research trials you may be doing.

GILBERT: Currently, I am conducting a federally funded functional neuroimaging study of children and adolescents with OCD. We are especially fortunate that Mary Phillips, M.D., Ph.D., recently joined the faculty at WPIC. Dr. Phillips is a leader in the field of neuroimaging research and has conducted several important studies of adult patients with OCD. She has brought her research team with her to Pittsburgh and, together, we are working towards the development of our pediatric and adult OCD research programs here. IOP patients have not yet been enlisted in research trials but opportunities to

and treatment that your group provides covered by private insurance, Medicare or Medicaid?

GILBERT: Our services are covered by a variety of private insurance providers as well as Medicaid and Medicare. We will work with some insurance providers to develop a single case agreement for payment, if indicated.

NEWSLETTER: Are there any scholarships or programs that will help families who cannot afford the treatment in the IOP program? What are they?

GILBERT: We offer payment plans, sliding scale fees as well as financial assistance to those who qualify.

NEWSLETTER: Who are the people on staff that will be treating these children? What are their backgrounds, credentials and experience? What is the ratio of staff to patient?

GILBERT: Our staff is comprised of a multidisciplinary team, consisting of a psychiatrist, psychiatric nurse clinician, psychiatric social worker, and several mental health clinicians. Our staff comes from a variety of backgrounds and experiences which contribute to the diversity of treatment modalities used in our program. The ratio of staff to patient is 1:3.

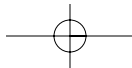
NEWSLETTER: Do you have non-intensive treatment for children and adolescents? What is involved in that?

GILBERT: We do not currently provide a lower level of treatment. If a child does not meet the criteria for an IOP level of care, we will assist the family in finding OCD specialists within the community for outpatient care.

NEWSLETTER: How does a family decide whether their child or adolescent should be in the Intensive Treatment Program or should be receiving weekly treatment for OCD?

GILBERT: At the time of the initial assessment, the clinician will help the family determine how disruptive the OCD symptoms are to the child and family. Generally, families that seek admission to our program are experiencing moderate to severe disruption in the daily functioning of the family/child.

NEWSLETTER: With whom and how should parents get in touch with Western Psych if they think their child would be a good candidate for this program?



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)

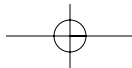
CALLING FROM OUTSIDE FLORIDA. OCF'S REGISTRATION NUMBER IN FLORIDA IS CH8507. Maryland: A copy of the documents and information submitted by the OCF pursuant to the Maryland Charitable Solicitations Act are available for the cost of copies and postage from the Secretary of State, State House, Annapolis, 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

TATION 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.

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