OCF Annual Conference

OCD NEWSLETTER

Denver July 20-22, 2001

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Dear Friends,

First I have to deliver a message on behalf of everybody at the Foundation: Susan, get well quickly. We desperately need your help at the Annual Conference in Denver.

Now I can start. Shortly after New Year's I trekked over to New Haven to visit with Drs. Robert King and Diane Findlay at the Yale Child Study Center. It was one of those miserable post-snow storm days where the parking lots are slush, every walkway and street is a narrow artery and all the street-side snow mounds are black. And, it was a Monday morning. Not a very auspicious prologue to what turned out to be an enlightening meeting about the services available for children and adolescents with OCD at the Center and, sadly, the services and facilities that these kids should have, but don't.

Let me just say: We are in a crisis situation where children and adolescents with OCD are concerned. Everyday we get frantic phone calls from parents trying to find both inpatient and intensive outpatient treatment for their children. By the time we hear from them, they are willing to travel anywhere in the country to get help. Unfortunately, we're not that much help to them.

There are many excellent practitioners who treat kids with OCD. The critical problem is the lack of inpatient and residential treatment centers and intensive programs for children and adolescents. At Yale Child Study Center, I learned from talking with Drs. King and Findlay, that, while there is no separate inpatient unit for children and adolescents with OCD, the Center staff can hospitalize them at Yale-New Haven Hospital under the auspices of Yale Medical School Psychiatric Department.

This means that while there are no beds assigned specifically to the Center's OCD program, the Center's staff can sometimes hospitalize a child who is in an acute situation. This is far from ideal because the OCD specialists aren't in charge of the child's treatment regimen.

This is also problematic because it's a general population ward with children with all kinds of problems. From personal experience, I can tell you that an adult or child with OCD is generally a rule-player, not given to acting out or aggression. Many of the treatment modalities used on a general psychiatric ward are irrelevant to a child with OCD's recovery. The expert consensus is that a combination of medication and cognitive behavior therapy is what a person suffering with OCD needs. What most of the intensive inpatient adult programs offer is an environment that is saturated with behavior therapy. This is what the kids need too. Obviously, this isn't offered on a general ward.

From the Foundation

There is help at the newly opened Anxiety Disorders Center at the Institute of Living in Hartford, Connecticut. The Institute has an inpatient ward for adolescents and children. They also have a school that is accredited by the State of Connecticut, as does Yale. But, while the doctors from the Anxiety Disorder Center can get a child admitted to the hospital, they are not in direct control of the patient and treat the child on a consultation basis. This means that the child is not in a setting that focuses only on behavior therapy, as is the case for adults at the OCD INSTITUTE and Rogers Memorial.

The OCD-Anxiety Disorder Service at New York Presbyterian Hospital in White Plains, New York is somewhat similar. A child or adolescent is admitted to the general inpatient ward but with a very specific OCD treatment plan designed by the staff of the OCD Service. The treatment plan is implemented by this group through visits and consultation with the general ward's staff. NYPH has a school accredited by the State of New York, which both inpatient and outpatient adoles-

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Call Me Irresponsible

By Fred Penzel, Ph.D.

The other day, a new patient of mine, a woman in her thirties, arrived fifteen minutes late for her appointment all out of breath. The lateness, she announced, was due to her having misplaced a very important list, which she was still unable to locate. When I inquired as to what was on this list, she informed me that it amounted to about twenty pages of notes she had made about every possible situation she had been in, over the last seventeen years, in which she might have been negligent and caused harm to another person. These notes, she believed contained vital information about her every word and movement on each of these various days. At least everything she could recall. These situations included possible traffic accidents, insults to others, property damage, the creation of hazards for others, and what might have been some sexual acting out.

A complicating factor for her was that when she tried to recreate one of these situations, she could not be sure about what she had or had not done. She would then repetitively worry that she had really done something wrong, and then become convulsed with anxiety. These concerns were what mental health practioners would call, obsessions. They might change from day-to-day, in terms of the particular incident, but all had the same theme.

Typically, when OC sufferers experience these types of thoughts, they react by performing compulsions of various kinds in order to relieve their anxiety. In my patient's case, this amounted to rereading the particular page of her list dozens of times in an attempt to review

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IN THIS ISSUE:

Bulletin Board

HABIT REVERSAL TREATMENT*

Dr. Thilo Deckersbach is conducting a behavioral treatment research study ("habit reversal") for OCD patients with tic-like ("just right") compulsions in the OCD Clinic at Massachusetts General Hospital in Charlestown, MA.
Habit reversal treatment has been a successful treatment for some patients with Tourette's Disorder. Because of the phenomenological similarity of complex motor tics in Tourette's Disorder and tic-like compulsions in OCD, Dr. Deckersbach anticipates that habit reversal will be an effective treatment for OCD patients with predominately tic-like ("just right") compulsions, such as, those involving symmetry, order or repeating. The treatment program includes 14 private sessions on habit reversal with weekly visits for the first two months and one visit every other week for the next three months. Habit reversal includes self-monitoring of compulsions and accompanying "just right" perceptions/feelings, along with relaxation techniques and engaging in competing responses that are incompatible with compulsions.
For more information, call (617) 724-6300, ext. 1340183 or e-mail Dr. Deckersbach at tdeckersbach@partners.org. (*Funded in part by the OCF Research Fund.)

INTENSIVE BEHAVIOR THERAPY

The Center for Treatment of Obsessive-Compulsive Disorder at the University of Pittsburgh Medical Center Health System is offering an Intensive Treatment Program utilizing Exposure and Response Prevention. The programs vary from 3 to 5 hours a day and the therapy is available either 3 or 4 days a week. There are also low cost residential facilities available. For more information, contact Mark Jones, LSW, at (412) 624-4466 or e-mail him at jonesmr@msx.upmc.edu.

TREATING CHRONIC HAIR PULLING WITH SERTRALINE (ZOLOFT) AND HABIT REVERSAL

The Massachussetts General Hospital Trichotillomania Clinic and Research Unit are conducting a double blind research study using Zoloft and behavioral treatment for chronic hairpulling. This research study is free of charge.
You must meet the following criteria:

- no prior trials of Zoloft
- hairpulling symptoms for at least 4 months
- daily hairpulling for at least 1 month
- no history of seizure disorder
- must live in Massachusetts

For further information, please call Amanda Beals, M.Ed. at 617-726-9281.

INTRAVENOUS CLOMIPRAMINE STUDY CONTINUES

The New York State Psychiatric Institute is continuing its Intravenous Clomipramine Treatment Study through December 31, 2001. Intravenous Clomipramine may be helpful for patients who have not benefited sufficiently from other medication treatments. This double-blind study provides free hospitalization, free treatment and partial travel reimbursement. Prior research done on IV Clomipramine indicated a responder rate of 43% one week after the IV infusions for patients who had previously responded poorly to oral Clomipramine.
For more information, please contact Dr. Suzanne Feinstein at (212)543-5132.

DRUG STUDY FOR TREATMENT RESISTANT DEPRESSION

Bio-Behavioral Institute of Great Neck, New York, is conducting an investigational drug study using the combination of olanzapine and fluoxetine in patients with major depressive disorder. They are currently seeking adults between the ages of 18 and 65. This is a double-blind study with a comparator, but no placebo. To be eligible, patients must have failed to respond to an SSRI. Anyone interested in participating in this study should call Laura Donohus at (516) 487-7116 for more information.

UNIVERSITY OF MICHIGAN HOSPITALS OCD GENETICS STUDY

Researchers working with Gregory L. Hanna, MD, at the University of Michigan Hospitals are looking for individuals who developed OCD before the age of 15 and also have a sibling or second-degree relative (grandparent, uncle, aunt, nephew, niece, grandchild or half-sibling) with a history of obsessive compulsive sympthoms. Particiants must be at least six years old and available for interviewing and blood sampling. There is no treatment provided in this study, but participants can be receiving medication or other treatments during the study. All participants will be paid. The University of Michigan Institutional Review Board has approved this study. If you are interested in participating , please contact the study coordinator, Kristin Chadha, MSW at kchadha@umich.edu or (734) 764-0250.

DO YOU SUFFER FROM OBSESSIVE COMPULSIVE DISORDER AND LIVE WITHIN COMMUTING DISTANCE OF NYC?

Are you on medication but still suffer from OCD symptoms? You may be eligible to participate in a research study that would provide cognitive behavioral therapy and medication at no cost to you.
For more information, please call: The Anxiety Disorders Clinic, New York Presbyterian Hospital, New York State Psychiatric Institute/RFMH—(212) 543-5367.

BE ON THE LOOKOUT

Coming this Spring…....The Second Annual Long Island Obsessive Compulsive Disorder Family Day Picnic.
A day of fun for Family and Friends. For more information, e-mail: alimalis@aol.com.

BODY DYSMORPHIC DISORDER STUDY

Harvard Medical School seeks participants for a study on body image. If you are very concerned about some part(s) of your body which you consider especially unattractive and you think about this more than one hour per day, you may be eligible to participate in this research study. $35 stipend. Please contact Ulrike Buhlmann, M.S. MGH-East/OCD Clinic, Harvard Medical School, 13th Street, Charlestown, MA 02129. Tel. (617) 724-4354, fax: (617) 726-4078. email: buhlmann@wjh.harvard.edu

NIMH WEBSITE SPOTLIGHTS CLINICAL TRIALS

The National Institute of Mental Health website – www.nimh.gov – has added a new feature, "Focus on Clinical Trials." Located directly on the home page under "Breaking News", this feature will provide summaries and links to various NIMH clinical trials on a rotating basis.

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OCD NEWSLETTER

The OCD Newsletter is published six times a year.
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The Obsessive Compulsive Foundation (OCF) is an international not-for-profit advocacy organization with more than 10,000 members worldwide. Its mission is to increase research, treatment and understanding of obsessive-compulsive disorder (OCD). In addition to its bi-monthly newsletter, OCF resources and activities include: an annual membership conference; popular website; training programs for mental health professionals; annual research awards; affiliates and support groups throughout the United States and Canada; referrals to registered treatment providers; and the distribution of books, videos, and other OCD-related materials through the OCF bookstore and other programs.

When to "Let Go"

Treating Mental Compulsions

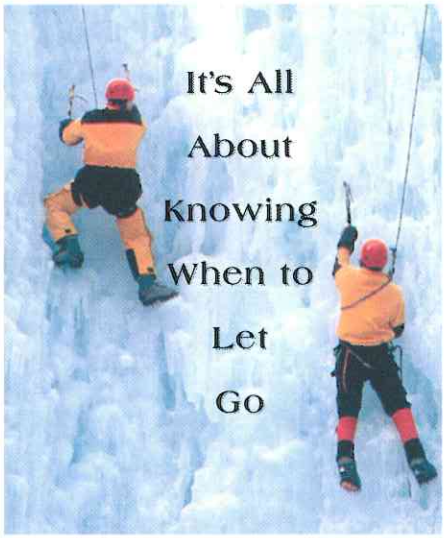
by Michael D. Alcée, M.A.

Cognitive Behavioral Treatment for OCD is founded on the counterintuitive yet empowering principle that in order to achieve freedom from our anxieties we must confront them in an active and eager fashion. For instance clients who have a contamination fear are encouraged to not only approach the dirty areas within their own houses but also to intentionally contaminate certain safe zones. Clients with obsessions of hurting others are encouraged to "bring them on" and accept the uncertainty that they might act on them. The list can go on but the point of this article is to differentiate between these kinds of obsessions and their closely related cousin, the "re-enactment" neutralization. Unfortunately, because of the widespread application of the "bring it on" principle, some clients mistakenly apply it to entities that are paradoxically best "brought on" by "letting go." In elaborating these variations on the OC theme, I will demonstrate how to more adaptively negotiate those "ify" moments when "bringing it on" may be counterproductive (i.e. promoting reassurance, certainty and perfection-seeking behaviors) while "letting go" may be the best recipe for success (i.e. fostering choice, uncertainty, and ambiguity-embracing behaviors).

The specific OCD variant discussed here is something that I call the "reenactment" neutralization. Since it is clearly defined in the research literature, let's start with the second part of this definition first. A neutralization is essentially a mental compulsion. It is a thought or group of thoughts used to ward off an unexplainable urge or fear. While the washer's and checker's anxieties are undone by a physical action (i.e. cleaning, checking), the neutralizer's are alleviated through repetitious rumination (i.e. Did I do or say that in the wrong way? Let me go over it again step by step and see if I did. It is not uncommon for these mental neutralizations to take on a more rigid form in which the person has specified formulas that are used to avert the perceived disaster. For example, a client who had morbid thoughts regarding family members (i.e. "I hope that my mother dies") engaged in a formulaic response ("clear what I just said") to protect against the feared outcome.

The re-enactment part of the equation refers simply to the replaying in one's mind of the offending event and/or behaviors that spawn the anxiety. Often these re-enactments involve a social situation in which the individual obsesses whether they said the right thing — replaying the interaction to see if they may have intentionally or unintentionally hurt the other person's feelings. They may also be preoccupied with how they were perceived, wondering if they appeared to be insensitive or unduly harsh (i.e., Do you think that she picked up the sarcasm in my voice when we were talking? Do you think he thinks I'm a mean person because I didn't say goodbye). Sometimes these anxieties do not occur immediately after the event but surface hours later. It is not unusual for them to occur after an argument since this event provides rich fodder for the ruminatively reenacting grist-mill.

The individual takes steps like a detective mentally piecing through the fragmentary clues of a crime, attempting to put closure on the case and declare the mystery solved (i.e., Though I was a little sarcastic I remember telling her that I was tired and had a long day. That should make it okay). As the analogy suggests, the search is one for blatant closure



and unequivocal certainty. This is a worthy goal in some situations (i.e., private investigator) but often OCDer's take this need for completion and perfection to a level that is not only impossible but also extremely debilitating. Often it spirals into a vicious cycle of internal questioning and doubting. Like a virus, the spiral seems to take on a life of its own, spawning more doubts and counter-doubts. The repetitive mental loop tape is so prevalent that it may appear to an insensitive outsider to be the OCDer's favorite sadistic mind game, embodying a veritable sisphyian task. Others who are not aware of OCD and its tormenting effects on one's esteem and confidence may try to dismiss the seriousness of these thoughts, telling the individual to just "shrug it off" and "stop thinking like that!" Luckily, due to recent advances in the knowledge regarding OCD, clients are no longer in a position to feel cursed by ineffable forces; rather, with skilled clinicians they can learn how to actively remove themselves from the situation and lead more productive and fulfilling lives!

In order to illustrate the concepts in this article. I will discuss a case example that not coincidentally occurred as a result of just the type of confusion regarding the "bringing it on" principle that I seek to redress in this article. The interaction occurred in a recent OCD group meeting that seemed to be a fairly typical illustration of the success of CB group therapy for OCD. What was unusual however was that the member who brought concerns was a 'veteran' who had successfully implemented CB principles into her life and seemed to be well on her way towards freedom. More importantly, despite being well-versed with the therapy, she seemed at a loss to explain how come the "usual techniques" were not working with this particular problem. Addressing the group with hesitancy and confusion she said: "When I try to think about it more and try to feel the threat of it more, it doesn't go away like when I work with my other obsessions and I can't understand!" Emphasizing the degree of difficulty with which she was plagued, she added : "I don't know. It's much easier to work on the other stuff. This mental stuff is really tricky."

A well-intentioned member in the group, eager to help this obviously distraught woman, advised her to bring the thoughts on despite their difficulty and continue more intently with the therapy. In the spirit of a good radical behaviorist he advised her to actively court the thoughts and aggressively preview them. The logic and rationale behind this extremely well-intentioned advice seems quite sound on first examination. After all, what could be more empowering than asserting one's active control of thoughts and feelings? What could be wrong with refusing to be passive and fearful in the face of the spike?

While I was taken by this group member's unbridled enthusiasm for the therapy, it seemed on closer inspection to be a little too cavalier and misdirected given the specifics of the other member's experience. For her, replaying the obsessions was not a fear; it was a desire! For her, letting go and embracing ambiguity/uncertainty meant doing the opposite. Instead of acting she needed not to act! In fact, acting (i.e. letting herself continue to think the thought and analyze the situation) would only be a reassurance, a hopeless attempt to undo and ward off the OCD anxiety. An intentional flooding exposure (purposefully summoning the thoughts) would be contraindicated because it would just serve to feed the spiral of escape. Remember here we are dealing with a neutralization and not an obsession. If it were an obsession, then the "wham-bam" exposure exercise would be perfectly logical and effective. This subtle but important distinction changes the game rules completely! By just entertaining the thoughts, one is giving in to OCD's signature anxiety: the urge to ritualize. "Letting go" however, helps the OCD individual come to terms with this anxiety instead of continuing to flee from

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Book Review

Imp of the Mind*

by Lee Baer, Ph.D.

Dr. Lee Baer's new book is an outstanding, thought-provoking, insightful discussion of why people have obsessive bad thoughts and how to treat them. It is written for those who suffer from such thoughts, especially those who have obsessive-compulsive disorder (OCD), but it is also a must read for clinicians. Dr. Baer is a Harvard psychologist, behavior therapist and author with 20 years of experience in treating OCD. He is also director of OCD research at Massachusetts General Hospital and at the OCD Institute at McLean Hospital.

Dr. Baer's consideration of the problem of bad thoughts is refreshing, different, and it opens a needed discussion. He explains in Part One why we all have bad thoughts at times and why individuals who have OCD particularly suffer from bad thoughts. In Part Two, he discusses not only the gold standard of treatment, the behavior therapy called exposure and response prevention (ERP), but he presents a type of cognitive therapy (CT) designed for OCD, which has been found to be as effective as ERP! He also includes a chapter on medication.

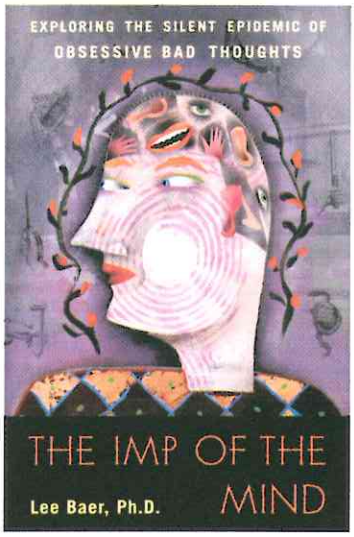
What captures the reader's attention is Dr. Baer's ability to stand back and take a Renaissance Man's approach to examining the problem of bad thoughts. He draws from literary resources, history, religion, evolutionary theories, various psychological theories (including psychoanalytic theory), neuropsychological research, and neuroimaging data. Somehow, he successfully weaves all these threads into an image that is enlightening.

In explaining why we have bad thoughts, he borrows from Edgar Allen Poe's short story "The Imp of the Perverse." Poe says we all have had impulses to say or do what our reason tells us not to do, experiencing "one unconquerable force which impels us... to its prosecution." This force is the Imp of the Perverse, for which the book is named.

Dr. Baer then aims to differentiate between harmless and dangerous thoughts. He lists psychiatric disorders such as depression, obsessive-compulsive disorder, Tourette's syndrome, or post-traumatic stress disorder (PTSD) which may be present in people who have severe bad thoughts. He provides criteria for each disorder to help readers to determine if they have OCD. He sees the Imp at work in different ways in these disorders. In PTSD, for example, it torments one with intrusive memories and images of actual traumatic events. In OCD the Imp deprives one of ever feeling certain that one would not act or has not acted upon an unacceptable thought.

Throughout the book, Dr. Baer keeps his message clear by identifying key points. One is "the Imp of the Perverse will try to torment you with thoughts of whatever it is you consider to be the most inappropriate or awful thing that you could do." For example, young mothers with postpartum depression often secretly have thoughts of harming their children. He estimates that there are about 200,000 women in this category every year, and there are even more mothers who are not depressed who have harming thoughts.

His chapter on what causes bad thoughts includes a discussion of how evolutionary theory explains our aggressive and sexual instincts. Social taboos lead us to believe that we should suppress socially inappropriate thoughts. Unfortunately, thought suppression paradoxically intensifies the thoughts, leading to torment in OCD sufferers.



Dr. Baer cites findings of neuroimaging and neuropsychological studies. They conclude that areas of the limbic system that control emotionally driven behavior as well as the orbital frontal cortex, which inhibits impulsive behavior, are involved in OCD. According to neuropsychologist Dr. Cary Savage, the symptoms of OCD occur only when "both (1) emotional systems of the limbic system and (2) cognitive systems of the prefrontal cortex are malfunctioning." These factors lead to OCD sufferers placing too much emotional importance on their thoughts, followed by worrying about them excessively. In addition, they have problems with episodic memory, the ability to re-create past events in your head. OCD sufferers also tend to have personality characteristics of being overconscientious, perfectionistic, and highly sensitive.

Tying these findings together, if you have someone who is overconscientious, attaches excessive emotional meaning to not thinking about thoughts of harming, cannot inhibit these thoughts or worrying about having them, and cannot remember whether they acted on these thoughts or not, you're likely to have someone with OCD.

So how does Dr. Baer suggest, in Part Two, that we treat these obsessions? He certainly subscribes to using ERP, the treatment with the best track record, in most cases. He gives a clear explanation of how exposure techniques rely on the principal of habituation of anxiety. He provides actual tasks to use for *in vivo* exposure therapy. He also includes creative examples of scripts used for imaginal exposure.

He also presents cognitive techniques found by Van Oppen and Emmelkamp to be as effective as ERP. They designed CT techniques to fit the cognitive errors found in OCD sufferers. These cognitive errors include overvaluing particular thoughts, the need to control thoughts, overestimating danger, intolerance of uncertainty, perfectionism, and excessive responsibility. CT techniques used include doing a thought suppression experiment, psychoeducation about how thoughts and emotions are related, the downward arrow technique, assessing advantages and disadvantages of bad thoughts, performing behavioral experiments, questioning the basis of beliefs, cognitive continuum technique (e.g., rating how evil one is, 0 - 100), and calculating the probability of danger. Dr. Baer brings the techniques to life using a case study. While some of these techniques are familiar, the packaging of them as a coherent treatment approach for OCD is new.

Why does this brand of CT work, when others have not? Dr. Baer acknowledges that the CT outlined inevitably includes some exposure, e.g., in doing behavioral experiments. What if clinicians have simply de-emphasized the cognitive piece of ERP, since the exposure piece has been so powerful? One would like to see research that replicates the findings reported here. First, the challenge would be to isolate CT without exposure components and ERP without the cognitive components, if that is possible.

Nonetheless, couldn't CT and ERP just get along? Probably most clinicians treating OCD will continue to use ERP as a first line of intervention, but perhaps using some of the CT techniques included here could enhance ERP. More importantly, in cases in which ERP fails or the patient refuses to do it, CT may be worth pursuing. Dr. Baer notes that patients with religious obsessions may refuse imaginal exposure if they believe that thinking the thought is a sin, for any reason. CT may be their best option.

Dr. Baer has certainly accomplished his stated mission in this book, to reduce ignorance about why we have bad thoughts and to reduce the torment patients experience from them. He has additionally broadened the discussion of treatment options greatly. If you have troubling obsessions, you will probably find a story close to yours in this book. If you enjoy the writings of someone who combines a passion for his work with creative insight about a complex problem, you will find this book a treat.

Review by Patricia Perrin, Ph.D.

**Available through OCF. Please call (203) 315-2190 ext. 13 to order.*

Bulletin Board

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The National Institute of Mental Health is part of the National Institutes of Health, which is the Federal Government's primary agency for biomedical and behavioral research. NIH is a component of the U.S. Department of Health and Human Services.

GENETIC STUDIES

At the Yale Child Study Center, we are conducting research with families in which there is at least one person affected with OCD. The goal of these studies is to find genetic and non-genetic factors that influence the onset and course of OCD. Genetic studies suggest that there are several forms of OCD, and at least for some patients OCD is familial. This means that having one affected family member increases the possibility of having other first degree family members affected as well. While there is no direct benefit to participants, we hope that these studies will contribute to a better understanding of the causes of OCD, therefore leading to more effective treatments. The project involves answering clinical diagnostic interviews and having a blood sample drawn (from which DNA is going to be extracted). The interviews and blood work can be done at the family's convenience.
For more information, please contact:
Dr. David Pauls, Yale Child Study Center, 1-877-YALE-OCD.

DIMENSIONAL Y-BOCS STUDY

At the Yale Child Study Center we are conducting a project designed to validate a new instrument for the assessment of OCD patients, the Dimensional Yale-Brown Obsessive-Compulsive Scale (DY-BOCS). This questionnaire is designed to evaluate the nature and current severity of obsessive-compulsive symptoms with a multi-dimensional approach. We hope that this dimensional approach to OC symptoms may be useful for improving clinical, genetic and neurobiological studies. It is also possible that using a multidimensional severity scale in treatment studies will reveal clinically relevant patterns of response. The interviews take approximately 2 hours to complete. Each participant receives $20 as reimbursement.
For more information, please contact:
Maria Campos, MD, Yale Child Study Center,
230 South Frontage Road, PO Box 207900
New Haven, Connecticut 06520-7900
Tel. (203) 737-5187 Fax: (203) 785-7611.

SURVEILLANCE STUDY

At the Yale Child Study Center we are conducting a study which focuses on how certain bacterial infections and life stressors affect tics and obsessive compulsive symptoms in children between 7 and 17 years old. For this study, we will follow about 80 families over the course of 2 years to determine whether symptoms worsen as a result of major life stressors and strep throat infections. Data from this study may lead to new treatment options for individuals who have these conditions. The initial visit entails diagnostic interviews, which survey the child's personality and lifestyle at home and school; blood sampling for DNA analysis and cheek/throat swab; neuropsychological assessments, which evaluate the child's cognitive and motor functioning (i.e., complete puzzle designs); and an MRI scan. Participation entails brief monthly telephone calls, to check on the child's current medications and health; periodic blood sampling for DNA analysis and cheek/throat swab, which occur every 4 months; and interviews. The participant receives substantial reimbursement for his or her time and effort: $85 for the initial visit plus $60 with an MRI; $25 each 4 month visit; and up to $95 should an exacerbation occur.
For more information, please contact:
Maria Campos, MD, Yale Child Study Center
230 South Frontage Road, PO Box 207900
New Haven, Connecticut 06520-7900
Tel. (203) 737-5187 Fax: (203) 785-7611.
Email: maria.campos@yale.edu

NEUROIMAGING (MRI) STUDY

At the Yale Child Study Center we are conducting a study which focuses on the differences in brain structure and functioning among individuals with Tourette Syndrome (TS), OCD, and attention deficit hyperactivity disorder (ADHD) and unaffected individuals. The protocol includes a MRI scan, neuropsychological assessment and diagnostic interviews. The individual must come for one full day and will receive a $80 reimbursement. The diagnostic interview surveys the individual's personality and lifestyle at home and school; the neuropsychological assessment evaluates the individual's cognitive functioning and the MRI scan takes 1.5 hours, during which the individual is asked to perform certain tasks (i.e., complete puzzle designs) part of the time.
For more information, please contact:
Amy Basile, Yale Child Study Center
230 South Frontage Road, PO Box 207900
New Haven, Connecticut 06520-7900
Tel. (203) 785-4220 Fax: (203) 785-7611.

PROSPECTIVE STUDY

At the Yale Child Study Center we are conducting a study in which we follow children who are at genetic risk for OCD and Tourette Syndrome year after year, starting from when they are 3 to 5 years old, over the period of time when they might start having symptoms. Our criteria include: 1 or more children without symptoms who is 3 to 5 years of age, and an older sibling or parent who is affected with TS or OCD or both. We do structured psychiatric interviews with each family member one time and after the first year only do interviews about the child we are following. We have different tests for younger and older children that are age appropriate. We get DNA information sometime over the period that the family is in the study, either drawing blood or taking cheek swabs. In addition, we get information from the child's teacher about how he/she functions in the classroom. There are no benefits to the families in the form of monetary payment, but we do send out a report each year on their child's test results, which may help the parents to know more about their children's strengths and weaknesses, and could lead to further evaluations by the school system if there seems to be a problem.
For more information, please contact:
Michelle Shanahan, Yale Child Study Center
230 South Frontage Road, Room # IG-63 SHM
New Haven, Connecticut 06520-7900
Tel. (203) 737-5017 Fax: (203) 785-5908.

What Your Research Dollars Are Doing

Dear Foundation Members,

Dr. Thilo Deckersbech

Our project "Habit reversal for tic-like compulsions" investigates the efficacy of a behavioral treatment called "habit reversal" for tic-like ("just right") compulsions in individuals with OCD. * This technique has been shown to significantly reduce tics in individuals with Tourette's Disorder. Due to the phenomenological similarity of complex motor tics in Tourette's Disorder and tic-like compulsions in individuals with OCD we anticipate that this treatment will help to reduce the intensity and frequency of tic-like compulsions.

Over the past months we have been adapting the habit reversal treatment for treating tic-like compulsions in OCD. And, we are in the process of receiving IRB approval and we have just started to recruit patients for this study.

We are looking forward to the continuation of this project and would like to thank you again for your financial support.

Sincerely,

Thilo Deckersbach, Ph.D.

Dr. Deckersbach is a Research Fellow in the Obsessive-Compulsive Disorder Clinic and the Cognitive-Behavior Therapy Program at Massachusetts General Hospital in Charlestown, Massachusetts.
Dr. Deckersbach received an OCF Research Award in 2000.
**See Bulletin Board for details on participating in this study.*

Tax Tips: Charitable Remainder Trusts

by Kathleen Bornhorst, J.D.

Charitable Remainder Trusts are trusts that provide fixed or variable payment to individuals for a period of years or for their lives. When the specified period ends, the property in the trust is paid to charity. A charitable deduction is allowed, based on the current value of the charity's right to receive the property at the end of the trust term.

Charitable Remainder Trusts are of two types:

the Charitable Remainder Annuity Trust; and

the Charitable Remainder Unitrust.

Gifts to Charitable Remainder Trusts may be made during a taxpayer's lifetime or at his or her death.

Charitable Remainder Annuity Trusts

The taxpayer places property (cash, stock, land, etc.) into the trust and receives each year an annual payment equal to a fixed percentage of the value of the donated property. The annuity stays the same during the term of the trust, regardless of whether the trust property increases or decreases in value. No further donations may be made to an annuity trust.

For example: On January 1, 2001, the taxpayer placed $100,000 in a trust, which directed that 5% of the initial value of the trust (i.e., $5,000) will be paid to the taxpayer in quarterly installments of $1,250 during his lifetime and, following his death, to his wife; following her death, the property will be distributed to a qualified charitable organization. The taxpayer will receive $5,000 each year while he is alive and his wife will receive $5,000 per year following his death. If when both husband and wife die in 2010, the trust has grown to $125,000, that will be paid to the charitable organization.

Charitable Remainder Unitrusts

The taxpayer places property (cash, stock, land, etc.) into the trust and receives each year an annual payment equal to a fixed percentage of the value of the donated property, as revalued each year. The amount the taxpayer receives thus changes, depending on the performance of the trust. Property may be added to a unitrust.

For example: On January 1, 2001, the taxpayer places $100,000 in a trust, which directs that 8% of the initial value of the trust will be paid to the taxpayer in quarterly installments during this lifetime and, following his death, to his wife; following her death, the property will be distributed to a qualified charitable organization. The taxpayer receives $8,000 in 2001. If, on January 1, 2002, the trust is worth $104,000, the taxpayer will receive $8,320 that year. After that, payments will increase or decrease depending on the value of the trust. If after the death of husband and wife the trust has grown to $110,000, that amount will be paid to the charitable organization.

Advantages of One Form over the Other

Advantages of Annuity Trust over Unitrust:

The taxpayer is guaranteed a fixed amount each year.

There is no need for annual valuation of assets. (This is not an important consideration when assets are easy to value).

Advantages of Unitrust over Annuity Trust:

If the trust grows in value, the taxpayer benefits from the growth; his annuity is better able to keep up with inflation.

The taxpayer can add property to a unitrust. If he wishes to spread out his contributions to the trust (e.g., $50,000 this year, $50,000 next year, etc.), his use of a unitrust would require no new instrument.

A unitrust can provide that if (a) trust income is less than (b) the unitrust amount, the trust can defer the difference between the two amounts until income becomes available. (This is an important consideration, when the asset donated by the taxpayer may be difficult to sell or produces a low rate of return.) An annuity trust cannot have such a provision.

Computing the Charitable Deduction

The IRS provides detailed charts for computing the charitable deduction. If your trust provides that you will receive distributions for the rest of your life, your deduction will be based on IRS life expectancy tables. In addition to the length of the trust term, the IRS takes into account current interest rates (the "applicable federal rate"), the timing and frequency of your payout (monthly, quarterly, etc.), and the type of trust that you establish (annuity or unitrust).

Typical computations:

1. In January 2001, the taxpayer places $100,000 cash in a unitrust, with a 6% annual payout, payable in quarterly installments. When he dies, the property in the trust will be paid to the charitable organization.

His deduction:

Age at Time	Trust Funded Deduction
60	$34,559
70	$48,541
80	$64,004

2. Same facts as before, except the taxpayer provides that his wife (also his age) will receive the same 6% annual payment when he dies. On the death of the survivor, the property then in the trust will pass to the charitable organization.

His deduction:

Age at Time	Trust Funded Deduction
60	$23,267
70	$36,394
80	$52,957

All deductions are subject to the percentage limitations (typically, 50% of adjusted gross income for cash donations and 30% for gifts of appreciated stock and real estate); alternative minimum tax rules (for deduction taken on the built-in appreciation of donated property); and the carryover rules (if you can't use the full deduction this year, you will have the next five years to use it).

Taxation of Distributions

Distributions from a charitable remainder trust are usually taxable to the taxpayer. The trust computes its income for the year, like an ordinary trust. The distribution to the trust beneficiary will be classified as follows:

1. As taxable "ordinary" (interest and dividend) income; and to the extent the distribution exceeds the trust's ordinary income.

2. As taxable "short-term capital gain" income; and to the extent that the distribution exceeds the trust's combined ordinary and short-term capital gain income.

3. As taxable "long-term capital gain" income; and to the extent that the distribution exceeds the trust's combined ordinary and capital gain income.

4. As nontaxable (e.g., tax-free municipal bond interest) income; and to the extent that the distribution still exceeds the combination of all these items, the balance will be attributable to.

5.Trust principal.

If substantially appreciated securities are contributed to the trust and the trust sells the securities, the taxpayer will incur tax on his distribution. If cash is contributed and the trustee (of a unitrust) invests in tax-free municipal bonds, the taxpayer will receive tax-free income.

Closely Held Business Stock

A charitable remainder trust is subject to some or all of the "private foundation" rules. If the trust provides that a public charity, e.g., the O.C. Foundation, will receive the property outright when the trust expires, the trust will not be subject to the "excess business holdings" rules, which prohibit private foundations from holding substantial interest in

(continued on page 11)

When to "Let Go"

(continued from page 3)

it. In other words, "letting go" is paradoxically the path towards ultimate freedom and control!

There are at least four pillars to effectively confront and manage neutralizations using CBT:

Detection-Acknowledgement , Exposure-"Letting Go", SUDS monitoring-Positive Self Statements, and Cognitive Restructuring.

Identification/detection involves a careful and systematic (not perfectionistic!) exploration of the thoughts in order to determine whether they constitute an obsession or a neutralization. The most useful and penetrating questions revolve around the kind of intention one has with respects to thinking the thought. Am I seeking to reassure myself or escape anxiety by replaying this event? Is thinking or analyzing this thought preventing some feared danger, disaster, or catastrophe? Though this feels like life or death is there some part of me that thinks/feels that this danger is "over the top" or "far fetched?" These are tough questions to answer in the midst of an obsessional urge. This is tricky because often times the individual will find highly elaborate ways to rationalize and intellectualize why this mental behavior is justified. In the final analysis, these compelling explanations, however, mask a more profound difficulty – confronting and accepting ambiguity.

Now that we have established some pragmatic steps for detecting neutralizations I would like to delve into a somewhat more difficult yet integral part of this most important first step: acknowledgement. Acknowledgment here is somewhat analogous to the individual with an alcohol problem who comes to recognition that this is a legitimate issue – something that is preventing him or her from living his/her life to its fullest potential. This may be a very emotionally loaded issue for OCD sufferers who will have a difficult time initially accepting neutralization as a potential problem. In order to make it easier to address, I like to envision the therapy as a progression towards freedom – a journey towards helping the OCD individual tap into his/her many and wide talents and gifts. Acknowledging how neutralization (and its accompanying perfectionism) may be hindering that growth is a difficult but crucial step that can be addressed sensitively and humanely. To this end, in the beginning stages it might be helpful to note those instances where one is somewhat suspicious that he is experiencing a compulsion to replay the event in his head. Together with a trained therapist, these thoughts can be explored to determine if they are in fact neutralizations.

The next step involves the exposure that I have outlined to be unique to neutralizations: "letting go." Practice with this exposure entails letting go of the need for perfection, closure, and reassurance. In other words, the sufferer has to accept the ambiguity and uncertainty that he may have caused harm, said the wrong thing, etc. In the process, he prevents the overwhelming need to escape the anxiety.

In the beginning stages of treatment, one may entertain the idea rather than the act of letting go (i.e. not replaying/reanalyzing). One would focus on embracing the uncertainty that results from not answering the questions. Initially, this may be a very difficult task.

This basic principle of letting go is by far the most empowering and adaptive choice in the given context. Furthermore, it fits like a glove into CBT treatment for OCD. By all tokens, it is a mental exposure and response prevention turned on its head! In this scenario the exposure comes in not doing anything! One allows thoughts to float in one's head like the Buddhist monk who does not seek to attend

"It is not uncommon for these mental neutralizations to take on a more rigid form in which the person has specific formulas that are used to avert perceived disasters."

to or fix the thoughts but just let them pass through. "Let it flow, let it float" is a mantra that I use in therapy to keep this zen-like frame of mind. For those who like a more active approach, humor can also be act a useful "letting go" exposure; it works by challenging the danger with in an impishly rebellious way.

An important caveat with "letting go" involves an all too common "beginner's mistake." With the eagerness and enthusiasm to master this difficulty, some clients inadvertently end up suppressing their thoughts instead of letting them come in and float over them. Research by Wegner has consistently found that the more an individual tries to suppress a thought or idea, the more it comes back. In fact, he found that it not only rebounds (hence he called it the "rebound effect") but that in comes back with a vengeance – with greater intensity and frequency. This caveat illustrates the need for a wholehearted acceptance of the risk. Please note that perfection is not a goal here; that is exactly what we are working against! Rather, acceptance of what is and a striving towards the balanced state of confronting the fear and detaching oneself from its grips.

The next step involves SUDS assessment (subjective units of distress) and positive self-statements. These are two time-tested approaches towards managing the anxiety in the moment of anxiety. As you are "letting go" and practicing your exposure, assess your willingness to embrace that risk and take that chance using a SUDS scale (1-10, 10=high anxiety). Ask yourself, how much are you able to risk accepting this uncertainty? Optimally, one should work through a hierarchy where challenges are at a 5 , 6 or 7 level. Furthermore, as one is going through this very difficult experience, it may help to positively reward yourself by saying such thing as "I am actively confronting my fear and working my way towards freedom." The positive self-statements that can foster CB therapy are limitless; they are crucial to making CB treatment a winning formula.

The last pillar for effectively confronting and managing neutralizations comes at a deeper but extremely important level. It involves the perfectionist thoughts that often underly the neutralizations (i.e., I must be a perfectly moral individual. I should know the answers to all questions). CB therapy works on restructuring these distorted and maladaptive thoughts such that they are more realistic and rational (i.e., I don't have to be perfect in order to hold moral beliefs). In other words, treatment aims at helping OCD individual to stop placing god-like demands on themselves and embracing themselves as fallible, imperfect human beings who sometimes have morbid thoughts and often do make mistakes.

There is an apocryphal story that illustrates this need for closure and certainty that we all, even the greatest of humankind, to some extent need and crave. They say that when Beethoven was a little boy his mother used to play an unresolved chord (i.e., neither major nor minor) because she knew he would be unable to resist getting up from his bed to play note that would complete it!

The need for closure is a natural human inclination as we all know from the common experience when somebody forgets to complete the cadence for the melody of a well-known song. For the OCD sufferer this need is so pronounced that it prevents these individuals from really tapping into their many gifts and talents. Furthermore, it provides them with much unwanted duress. Consequently, the overall goal of therapy is to help the client appreciate the beautiful music of ambiguity. In other words, instead of feeling the need to know what musical key they are in or whether the cadences resolve, they can accept that hovering quality that exists in a suspended chord. Like the 20th century musicians who broke away from the formal rigidity of classicism (i.e., the modal styles of Debussy and Ellington), they are encouraged to relish the mystery and wonder of ambiguity with open eyes and open ears!

Research Digest

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

The following is a selection of the latest research articles on OCD and related disorders in current scientific journals.

Although selective serotonin reuptake inhibitors (SSRIs) are the medications of choice for OCD, between 40% and 60% of patients do not respond sufficiently. The addition of neuroleptics (also called antipsychotics) has been effective for many of these partial- and non-responders. The newer atypical antipsychotics have fewer adverse effects and are being researched as augmenting agents. Atypical antipsychotics available now are clozapine (Clozaril), olanzapine (Zyprexa), quetiapine (Seroquel) and risperidone (Risperdal) with ziprasidone (Zeldox) soon to be released. To date, there have been no trials of quetiapine or ziprasidone augmentation, although based on their tolerability they will be used as augmenting agents. The response to clozapine augmentation is also undetermined. In the summer 2000 Research Digest we included an abstract presenting results of risperidone augmentation of SSRIs in OCD patients not responding to the SSRI (McDougle CJ, Archives of General Psychiatry, 57:794-801, 2000). Fifty percent of these patients responded to the addition of risperidone. The following book chapter reviews neuroleptic treatment for OCD.

The role of neuroleptics in treatment-refractory obsessive-compulsive disorder

C.J. McDougle, C.N. Epperson and L.H. Price, pages 371-391

In: Goodman WK, Rudorfer MV and Maser JD (eds), Obsessive-Compulsive Disorders: Contemporary Issues in Treatment, Lawrence Erlbaum: Mahway, NJ, 2000

This chapter reviews the use of neuroleptics as single and augmenting agents in the treatment of OCD and OC spectrum disorders. Both the older neuroleptics such as haloperidol (Haldol), and the newer atypical neuroleptics are discussed. The relationships between OCD and Tourette's Syndrome, psychosis and stimulant abuse are also explored and considered in terms of neuroleptic treatment.

The following three studies investigated olanzapine addition to SSRI treatment in OCD patients who had not responded well to an SSRI. The response rate and number of patients in each trial are given. Sedation and weight gain were the most common side effects in all three studies. There have been concerns that these newer neuroleptics may worsen the OCD. This has not occurred in these studies or in other augmentation studies. The cases that have been reported have occurred in patients diagnosed with a psychotic disorder, rather than OCD (McDougle CJ, Archives of General Psychiatry, 57:794-801, 2000).

Augmentation of SSRI response in refractory OCD using adjunctive olanzapine: a placebo-controlled study

Presented at the 39th Annual Meeting of the American College of Neuropsychopharmacology, San Juan, Puerto Rico, December 10-14, 2000, A. Bystritsky, D.L.Ackerman, R.M. Rosen et al.

Double-blind, placebo-controlled study, in which 26 OCD patients were given either olanzapine (up to 20 mg/day) or placebo in addition to the SSRI. Six patients (46%) responded to olanzapine augmentation of the SSRI. No patients in the placebo group responded.

Olanzapine augmentation of fluvoxamine-refractory obsessive-compulsive disorder (OCD): a 12-week open trial

Psychiatry Research, 96:91-98, 2000, F. Bogetto, S. Bellino, P. Vaschetto et al.

Open trial in which 43.5% of the 23 OCD patients responded to olanzapine (5 mg/day) augmentation of fluvoxamine (Luvox). Researchers conclude that this is a promising strategy, especially when schizotypal personality disorder is present.

Olanzapine augmentation for treatment-resistant obsessive-compulsive disorder

Journal of Clinical Psychiatry, 61:514-517, 2000, L.M. Koran, A.L. Ringold and M.A. Elliott

Open trial in which 3 of 10 patients (30%) studied responded to olanzapine (up to 10 mg/day) augmentation of fluoxetine (Prozac). Researchers suggest the need for controlled trials comparing risperidone and olanzepine augmentation.

In summary, for OCD patients with insufficient improvement to SSRI treatment, a trial of antipsychotic augmentation may be warranted. For those with comorbid tics, haloperidol has proven efficacy; without tics risperidone and olanzapine have growing evidence supporting their benefit in up to half of patients receiving them. Whether the other atypical antipsychotics will also help awaits further study.

To balance the preceding articles on medication treatment, the following article by OCD mavens Edna Foa and Jonathan Abramowitz reminds us of the proven efficacy of behavior therapy as a treatment for OCD. Their research supports the beneficial use of behavior therapy, even in those patients with a major depressive disorder.

Does comorbid major depressive disorder influence outcome of exposure and response prevention for OCD?

Behavior Therapy, 31:795-800, 2000, J.S. Abramowitz and E.B. Foa.

Studies that have examined the effects of comorbid depression on treatment response in OCD have yielded inconsistent results. This study looked at treatment outcomes for 15 OCD patients with comorbid major depressive disorder and 33 OCD patients without a major depressive disorder. All patients received intensive cognitive-behavioral therapy by exposure and ritual prevention. Improvement in OCD symptoms was observed in both patient groups, and treatment gains were maintained at an average follow-up of 4.3 months. There was a difference in the severity of OCD symptoms between groups, the nondepressed patients had significantly lower posttreatment and follow-up OCD severity scores. In considering the use of behavior therapy with depressed OCD patients, researchers recommend careful assessment of depressive symptoms. If depression is a result of impairment from obsessions and compulsions, the patient may be more willing to tolerate the exposure and ritual prevention exercises. On the other hand, if a patient with OCD is severely depressed and displays hopelessness and suicidal thoughts, his/her ability to perform behavior therapy exercises may be reduced and affect treatment. In such cases, researchers recommend therapy for depressive symptoms before beginning behavior therapy for OCD.

Overall, the best augmentation of SSRIs for most patients is behavior therapy, combining exposure and ritual prevention. Unfortunately such behavior therapy is not widely available.

Call Me Irresponsible

(continued from page 1)

all the events of the day on which the supposed event had happened. In this way, she believed she could reassure herself that the worst had not happened, and that she would therefore not have to feel guilty about anything. My patient believed that if she learned that she had actually harmed someone, she would feel a crushing sense of guilt she could not then live with. Either this would cause her to "go insane," or, according to her own rules, she would have to commit suicide. Because she had lost her list earlier in the day, she had spent many hours ransacking her house and car, and trying to mentally reconstruct everything she had written on her list. This, then, is a glimpse through the window of what is known as hyperresponsibility (HR).

I suppose that if you had to identify one of the chief hallmarks of OCD, it would be doubt. This is no ordinary doubt, however. This is a no-holds-barred debilitating, paralyzing doubt. It is pathological doubt, or, doubt raised to the level of an illness. When it occurs, the need to resolve it and find relief can grow to outweigh every other priority in a person's life. OC sufferers can become doubtful about anything the human mind can conceive. Although many OCD sufferers only worry about bad things happening to them, there are also many who, especially those with HR worry about others. Exactly why certain individuals with OCD can become doubtful about having harmed others in some way remains a mystery.

In some cases of HR, we see sufferers taking on an exaggerated and unnecessary responsibility for others' health, safety, and well being. They are not just partially responsible for what occurs in their dealings with others. They are totally responsible. In addition, their sense of what they are capable of doing to others is also exaggerated. For instance if someone without HR physically bumped into someone on the street, they might be concerned for that instant that they had hurt the other person, but then seeing that everything was okay, would then go their way without giving it another thought. A HR sufferer would immediately assume that they had caused serious injuries, and would obsessively worry about the bump for hours or days afterward convinced that the other person had sustained hidden internal injuries that had a delayed effect and was most likely hospitalized or dead. Subsequently, they might read the papers or watch the news to see if anything had been reported. They might even call the police or the local hospitals.

When driving, some HR sufferers have problems with what has become known as "Hit-and-Run-OCD." Every bump in the road may seem to them to be a body they have driven over. Every pedestrian, child playing, or jogger at the side of the road becomes someone he or she could have struck with his or her car. Even a blur or a shadow seen out of the corner of their eye can become a potential victim. Backing out of a driveway can become an excruciating task. Driving back and forth over the same route to hunt for bodies, or getting out to repeatedly check the car for dents or bloodstains can become a routine part of every trip.

Food preparation has always been a problem for people with HR-type symptoms. The sufferer's fear is that he will act negligently and serve spoiled, contaminated, or poisoned food to guests or family members. There may be thoughts that such things as household cleaners, bits of broken glass, insecticide, drain cleaner, etc. have somehow gotten into the food they are cooking, so all food must be prepared in an absolutely meticulous way to rule out all possible accidents. Fears of botulism or salmonella may lead to repeated hand washing, smelling or scrupulous examining of the food. One patient of mine would regularly call dinner guests after they had gone home to make sure they had not gotten ill or died. Many sufferers end up not being able to prepare food at all.

Dr. Fred Penzel

Conversations with others can also be potential mine fields. Every offhanded remark made to another person may later be reviewed to see if something offensive, overly critical, or insulting was said. Repeated questions or phone calling may follow these conversations in order to find out exactly what was said, or how the other person may have regarded it.

When someone with HR also suffers from contamination phobias, their main concern is with others, not him or her. Those with HR may also find themselves in a constant state of high vigilance, continually scanning the environment for possible hazards to others. If they spot a streetlight out or see a damaged traffic sign, they will be the ones to report it. If someone's car looks like it has a tire low on air, he or she will feel compelled to leave a note under the windshield wiper. They may be seen picking up pieces of broken glass in the street, or bringing outdated packages of food to show the supermarket manager. They may even restack the canned goods on the supermarket shelves so they will not fall on anyone and injure them. It is almost as if they have been appointed as the world's guardian and protector. It can often grow to become a full-time job.

HR becomes especially unpleasant when the obsessions have sexual themes. A common one among adult sufferers is the thought that there is a possibility that they may have acted in a sexually inappropriate manner to a child. I have met numerous individuals who feared that they had made sexually suggestive remarks that could corrupt children. Or even worse, that they have touched children sexually or exposed their bodies to them in some way. Even touching a child on the shoulder or getting an innocent hug may seem to them to be filled with sexual meaning. A strenuous attempt to avoid contact with children is the inevitable result.

While we know that OCD is a chronic disorder, you can recover with the proper treatment. Treatment for this type of OCD would, of course, involve the use of Cognitive/Behavioral Therapy (CBT), and the approach would be twofold. On the behavioral level, Exposure and Response Prevention (E&RP) would be the treatment of choice. In this type of therapy, the person with OCD rates his or her fears from least frightening to the most. With the help of a therapist, he or she gradually confronts these rituals. The goal is to build a tolerance to the anxiety and the anxiety-producing thoughts and situations.

By staying with the anxiety and not avoiding, the sufferer comes to learn the truth of the matter - that the anxiety eventually subsides, and that the dreaded event never happens. Thus, working in a step-by-step way via behavioral assignments, the sufferer can eventually be able to experience the thoughts or situations and not feel that they must react in any way. Ultimately, they can achieve the ability to accept the thoughts, even though they are extremely unpleasant.

Typical E&RP assignments would revolve around having the sufferer do things that usually causes him or her doubt. At the same time the therapist needs to expose him or her to the thought that he or she definitely did something careless and that the worst has actually happened or will happen. At the same time, the person with HR is discouraged from checking, questioning, or doing rituals to prevent the harm. A person with hit-and-run fears might carry out driving assignments in increasingly challenging situations, while listening to tapes telling him that he has run someone over. An individual with food fears could be asked to prepare meals and snacks for others, while keeping household cleaners or broken glass nearby, he would simultaneously be listening to audio exposure tapes telling him that they were poisoning or harming his loved ones.

Other E&RP possibilities, depending upon the symptoms, would be to bump into others

on the street, to criticize others in minor ways, to resist reporting possible public hazards, to resist calling the police or public agencies to find out whether accidents have recently occurred, ask others for reassurance or to call them to find out if they are all right, or to fight the urge to revisit and check the scenes where accidents or problems might have occurred.

On the cognitive level, sufferers are taught to challenge their beliefs about just how responsible they are for the safety and well-being of others, and in their dealings with others, what proportion of the responsibility is really theirs. The role of guilt is also examined, and a better understanding of what it is and what role it has to play with regard to people dealing rationally with real errors and mistakes. Further, the assumption that any given individual can and must be perfect and never do anything wrong or harm anyone else in any way is also challenged. In my own work, this type of therapy is brought in after the sufferer has made some progress with their behavioral work and begun to get a grip on his or her anxiety.

In my opinion medications, too, may have a role to play in treatment of HR. I think that if the sufferer is highly anxious and agitated or severely depressed, medication can prepare him or her for behavior therapy. Additionally, if obsessions are so strong and believable that an individual feels truly unable to approach behavioral assignments, medication may also have to be included in the treatment package. It is my opinion that medication should not be considered a complete treatment on its own. I also think it should, instead, be regarded as a tool to enable a person to successfully participate in therapy. Medication alone cannot teach someone suffering with OCD the new skills needed to confront the things that cause anxiety in a world full of risks that must be taken in order to live freely. Finally, it is my belief that medication cannot teach you to accept your disorder so that you can begin the process of change.

With proper treatment, HR sufferers can recover and live lives as normal and average as anyone else's. It takes hard work, commitment, and determination, but recovery is there if you want it.

Fred Penzel, Ph.D. is a licensed psychologist who has been involved in the treatment of OCD for over eighteen years. He is the author of the recently published self-help book "Obsessive-Compulsive Disorders: A Complete Guide To Getting Well And Staying Well." Dr. Penzel is the executive director of Western Suffolk Psychological Services in Huntington, New York, and is a frequent contributor to the OCF newsletter. He sits on the scientific advisory boards of both the Obsessive Compulsive Foundation and the Trichotillomania Learning Center. <penzel@attglobal.net>

From the Foundation

(continued from page 1)

cents can attend. For the younger children who are hospitalized there is an on-site school.

Yale Child Study Center, NYPH, the Institute of Living, the Center for the Treatment and Study of Anxiety in Philadelphia, St Louis Behavioral Medicine Institute, the Center for Cognitive Behavioral Therapy in Los Angeles and Rogers Memorial Hospital have intensive outpatient clinics with from one to five days-a-week treatment regimes. This list is not exhaustive.

These programs have arrangements with local hotels and other residential facilities, such as, the Ronald McDonald House in New Haven. However, if the family does not live within daily commuting distance of the site, a parent or family member has to temporarily "move" with the child to the city. This is not a "doable" alternative for many families.

According to sources at Rogers Memorial Hospital, the administration there is evaluating the possibility of opening a program for children and adolescents similar to its inpatient program for adults with OCD. Other institutions are studying the feasibility of starting an intensive child and adolescent program including the Mayo Clinic in Minnesota.

However, at this point we do not have sufficient services and facilities to treat all our children effectively. And, we still have the problem of schooling.

Lee Fitzgibbons, Ph.D., who is at the Agoraphobia and Anxiety Treatment Center in Bala Cynwyd, Pennsylvania, has a vision that needs to become a reality. She sees a treatment center for children with a school. The school would be for outpatients who needed it as well as inpatients. This sounds like the NYPH set-up, but with the added value of being just for kids with OCD.

We know there's a need and we have conceptualized the solutions. What can we do to bring these centers into existence?

We have to become vigilant on the federal, state and local levels about government funding and spending on mental health programs. We need to organize and lobby from the local to the state to the federal level for space in psychiatric facilities devoted to the treatment of children and adolescents with OCD. We need to lobby for funding for research into effective treatments for OCD and for a larger portion of the state and federal money that supports this research

Keep an eye on your state legislature, state department of mental health, and your state representatives in Washington. Find out who makes the crucial funding and budgeting decisions. Get in contact with them to support OCD-positive legislation. Tell them the OCD story and ask for help for our children. They are the future; we need to make sure that they can take their rightful places in it.

Regards,

Patricia Perkins-Doyle
Executive Director

Save The Date

On Thursday, May 31st, the 6th Annual Hudson Valley OCD Conference will be held from 1:30 PM to 9 PM at Marist College in Poughkeepsie, NY.

Darin Doughtery, M.D., Assistant Professor of Psychiatry, Harvard Medical School, will give the first evening keynote address in which he will take us to *The Frontiers of Neurobiological Research by Way of Neuroimaging*.

Fred Penzel, Ph.D., author of *Obsessive Compulsive Disorders: A Complete Guide to Getting Well and Staying Well*, will give the other evening keynote address in which he will present *What to Do when You Have a Loved One In Or Out of Treatment*.

For more information send email to chris.vertullo@marist.edu.

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The OCF as a partner of GreaterGood.com receives up to 15% of the sales price of any items by shoppers who have registered the OC Foundation as their charity of choice.

Go to the OCFoundation website, www.ocfoundation.org. Click on the OCF SHOPPING PLAZA and shop at the more than 80 retails listed on the GreaterGood.com Shopping Mall.

Western PA Affiliate Recognized

Joan Kaylor

The Obsessive Compulsive Foundation of Western Pennsylvania is the latest affiliate to join the OC Foundation. It was founded on February 22, 2000 and accepted by the Obsessive Compulsive Foundation's board of directors at its annual meeting on January 26, 2001.

The following is an interview with Joan Kaylor, who is the president of the new affiliate, about how the Western Pennsylvania Affiliate came into being.

OCF: What was your motivation for starting the Western Pennsylvania affiliate?

Kaylor: I served on the national board of directors for 6 years. When I came back home to Pittsburgh, I'd realized we really needed a local group to help people with OCD.

OCF: Who worked with you to set up the affiliate?

Kaylor: Dr. M. Katherine Shear, Dr. Frank Ghinassi, Jack Cahalane and Mark Jones of Western Psychiatric Institute and Clinic, Valerie Ruslavage of Solvay Pharmaceuticals, Cary Jones, Esq., and Donna Shirato and Laura Wilkinson of our trichotillomania support group helped me create the affiliate. Mark, Donna and Laura serve on the local board of directors with me.

OCF: Other groups are probably interested in following your lead. How did you do it?

Kaylor: First, get a core group of people together that share the same passion. Second – write a letter of intention to the national Foundation. They will send you a packet of information with a list of things to do. Third – Get the support of an Anxiety Disorders Treatment Group. Fourth – set up a non-profit corporation in you own state. You can file the documents yourself although we choose an attorney to help us. Fifth – you need by-laws. Sixth – complete all requirements from the national office.
One year or so later – an affiliate! Easy? No. Rewarding and necessary – Absolutely!

Congratulations, Western PA!
OCF Board of Directors

Please join us for TLC's 10th Anniversary

National Conference on Trichotillomania & Related Body-Focused Disorders

starts 6:30 pm Friday March 30, 2001
ends at noon Sunday April 1st, 2001

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The Trichotillomania Learning Center, Inc.
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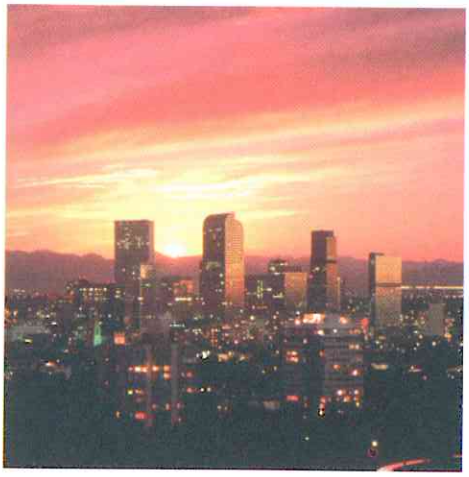

Denver at Sunset
Hope to see you there!

Tax Tips:

(continued from page 6)

businesses. Careful drafting of the instrument is required. Also, a donor must consider that the charitable remainder trust will be subject to the prohibitions against "self-dealing".

The Wealth Replacement Trust

You have to be charitably inclined to place property in a charitable remainder trust, since the charity will ultimately receive the property. However, if you give the property to the charity while you are alive, you may be able to reduce or eliminate the loss to your heirs by establishing a wealth replacement trust.

A wealth replacement trust can be established by a taxpayer when he establishes his charitable remainder trust. Let us assume that a taxpayer, age 60, establishes a unitrust for $100,000 in cash. The trust provides that each year, 6% will be paid from the trust in quarterly installments. Since the trust is a unitrust, it will be revalued each year. On his death, the property in the trust will be distributed to a qualified charitable organization. The trustee has taken the cash and invested in tax-free bonds.

As we see on page 6, the taxpayer's deduction for 2001 is $34,559. Let us assume that he is in the 50% bracket for purposes of estate and federal death taxes. Because he is in the 28% income-tax bracket, his deduction yields a saving of $9,677 in income taxes. With the $9,677, he funds a wealth replacement trust for the benefit of his wife and children; the trust then buys a single-premium life insurance policy for $45,000 on his life. When he dies, the $100,000 (plus any increment) will pass to the charitable organization in a fund in his name; he will have reduced his estate by $100,000 saving about $50,000 in federal and state death taxes; his wife will receive income from the wealth replacement trust ($2,700 + after tax per year); and his child will receive $45,000 from the wealth replacement trust when his wife dies. Net gain to the charitable organization: $100,000. Net loss to his estate: $5,000 (also, reduced income for his wife when he dies).

If he provides that his wife (age 60) will receive his 6% unitrust amount after he dies, his deduction will be reduced to $23,267 (see page 3); his tax savings will be $6,515; and his wealth replacement trust, funded with $6,515, will be able to purchase a joint and survivor life insurance policy for $44,000. Net gain to the charitable organization: $100,000. Net loss to his estate: $6,000. No loss of income to his wife when he dies.

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