

What Does OCD Look Like?

Me.
My Name is
Elizabeth.

Seven million children and adults
in the United States suffer from
Obsessive Compulsive Disorder.

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NEW HAVEN, CT – The Obsessive Compulsive Foundation's first-ever public awareness campaign is on the air on your local TV station now – and will be running for the next six months. A 19-year old University of Houston student, Elizabeth McIngvale, is the new national

spokesperson for the OCF. The campaign, "What Does OCD Look Like?" is targeted at the more than half-million teenagers in America with OCD.

"I want people to know that those of us who suffer with OCD are not freaks. OCD is a mental illness. We

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Message From the President

Dear Friends,

Since my last message to all of you, a lot has changed at the Foundation. I hope that you have had some time to visit our newly designed website (www.ocfoundation.org). The following people have worked tirelessly to make this happen: Daisy Sanchez, OCF program director; Marc Audet, web master; Michael Krantz, web designer; and Terry Murphy, a board member who was introduced in the last newsletter. We will constantly be updating the information on the site, as well as tweaking areas that require further work. Thank you all to those involved in creating our new website.



The Foundation recently completed a Public Service Announcement that should be blanketing the media now. It features Elizabeth McIngvale, a nineteen-year-old from Houston, Texas, who has OCD. Under Terry Murphy's direction and creative talents, the PSA entitled, "What Does OCD Look Like?" highlights an adolescent's struggle with the disorder. If you would like to see your local television stations air the PSA, please contact Patricia Perkins, our executive director, at pperkins@ocfoundation.org, for more information.

Now I would like to introduce two more members of the OCF Board of Directors,

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Bulletin Board

DO YOU SUFFER FROM TOURETTE SYNDROME OR CHRONIC TIC DISORDER?

Do you have motor and vocal tics (movements or noises/voices that are hard to control)? Do the tics occur several times a day? Have the tics occurred over a period of more than one year? Are you diagnosed with Tourette Syndrome or Chronic Tic Disorder? Do you have problems with your work or social life because of this?

Dr. Sabine Wilhelm of the Massachusetts General Hospital OCD/Tourette Syndrome Clinic and Research Unit is seeking participants for a treatment research study to reduce the symptoms associated with Tourette Syndrome or Chronic Tic Disorder. To be eligible, you must:

- have Tourette Syndrome or Chronic Tic Disorder
- be at least 16 years of age or older
- be able to commute to the Boston area
- be able to participate for 10 weeks

If you are interested in this study and believe you are eligible, please contact Dieu-My Phan at (617) 724-4354 or email her at dphan@partners.org

COMPULSIVE 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 compulsive hoarding, including problems with clutter, difficulty discarding items and excessive acquiring of items. 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 symptoms develop, how this problem is related to other psychiatric disorders and how best to assess the problem. This information may be helpful for identifying effective treatments in the future. Researchers are looking for people between ages 18-65 who have (1) problems with excessive clutter or (2) obsessive-compulsive disorder and (3) live within forty minutes of the greater Hartford or Boston areas. The study consists of a 4-hour diagnostic interview

about anxiety and mood symptoms followed by a 4-hour interview about clutter and acquiring. These interviews take place at the two sites. Additionally, the study will include a 1-hour visit to the participant's home where the participants will take part in an experimental task about removing clutter and another task about acquiring new items. Participants will be paid \$20/hr for their time and can make up to \$260. If you are interested in participating and have any questions, please contact Jessica Rasmussen, B.A., at Boston University at (617) 353-4213 or (617) 353-9610 or Buck Brady, B.A., at the Institute of Living in Hartford, CT at (860) 545-7574.

UCLA ANXIETY DISORDERS BEHAVIORAL RESEARCH PROGRAM OCD STUDY

Do you have excessive fears of contamination or infections? You may suffer from Obsessive Compulsive Disorder (OCD).

The UCLA Departments of Psychology and Psychiatry are studying ways of improving treatment for OCD, and we'd like to invite you to participate.

The study will consist of seven visits. During the first two visits, you will receive an initial psychiatric assessment and information on anxiety and its treatment. Three sessions of anxiety reduction exercises will follow. There will be a one-day assessment of outcome and another assessment four weeks later. Participants will be randomized to receive one or both of two study drugs or placebo.

Participants will receive a payment to help compensate them for their time and effort.

The study is conducted by Mark Barad, M.D., Ph.D.; Michelle G. Craske, Ph.D.; Alexander Bystritsky, M.D.; Bruce Naliboff, Ph.D.; and Edward Ornitz, M.D., Principal Investigators and Co-Investigators at UCLA.

If you are interested in obtaining further information about the study, please call Najwa Chowdhury at 310-825-3642.

BODY IMAGE TREATMENT RESEARCH STUDY

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

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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 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.

DISCLAIMER: OCF does not endorse any of the medications, treatments, or products reported in this newsletter. This information is intended only to keep you informed. We strongly advise that you check any medications, products or treatments mentioned with your treatment provider.

The Use of Family Therapy for Adolescents in a Residential Setting

By Bradley C. Riemann, Ph.D., and Katherine Tackes, MSW
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Adjunctive family therapy can be an important aspect in the treatment of adolescent obsessive-compulsive disorder (OCD). However, it can be very difficult to implement in a residential setting. The primary reason for this difficulty is that most residents come from great distances to participate in treatment, which does not allow for convenient, regular face-to-face sessions. Therefore, much of this work has to be done via teleconferencing.



Bradley C. Riemann, Ph.D.



Katherine Tackes, MSW

At the Child and Adolescent Center (CAC) at Rogers Memorial Hospital in Wisconsin, weekly family sessions are conducted in an attempt to enhance the effectiveness of the cognitive-behavioral therapy (CBT) used for OCD and to reduce family discord. These sessions include parents, resident, and their "case specialist." Sessions usually last one hour or longer. The case specialist is typically a masters in social work, with additional training in OCD and its treatment. Psychiatrists and other clinicians may attend roughly one-third of the time. On occasion, other family members may participate as well. It is estimated that 10-15% of residents will have all family sessions conducted by the phone, whereas up to 80% will have mostly phone sessions with occasional face-to-face sessions. Fewer than 5% will have the ability to do all weekly sessions face-to-face.

The initial family session typically consists of psychological education regarding OCD and CBT. Most families have done some research pertaining to these topics but clearly benefit from this step. For example, many families have never discussed why their child engages in compulsive activity. This information can provide valuable insight to family members regarding their child's illness. Discussing treatment and potential outcomes of treatment also provides the family with hope and confidence that their child can indeed improve. Next, establishing goals for family therapy sessions as well as treat-

ment as a whole are discussed. Each session also includes the resident reporting to the family about what he or she is currently working on in treatment, and how the family can assist in this process.

Several areas are commonly explored in the family sessions conducted at the CAC. An early topic of discussion usually is what the child and family has missed out on because of the OCD and how this has affected the family as a whole. This may also involve "picturing" what life would be like without OCD. Discussions also may examine how parental anxiety and depression may have affected members of the family and how that may or may not have had an impact on the current situation.

The "Blame Game" is also an important topic in family work. Blame can be manifested in many ways. Some families seem to blame the resident for all the family's problems. In other instances, the resident will blame the family for all of his or her problems, including having been sent to a residential program. We also may see a family and resident blame OCD for all the difficulties that are being exhibited by the adolescent, thereby allowing the resident to escape all accountability for his or her behavior. These scenarios are rarely entirely true, with the truth usually lying somewhere in between.

One of the biggest family issues we encounter is "enabling." This is discussed in length in many of the family sessions. Enabling can be exhibited by performing certain tasks for the adolescent (e.g., opening a door for him that he believes is contaminated) or by providing reassurance to him (e.g., "It is OK to touch that door handle, you won't get sick"). Enabling can be problematic in many ways, one of which is "buffering" the adolescent from the full impact of his OCD. While on the surface this seems to be a good thing, it can reduce motivation for treatment. We may frame enabling in a "having too much of a good thing" way, meaning that it is only right to try and reduce one's child's pain, but sometimes the results of these efforts make the situation worse not better. On occasion, families will state that they clearly see what they are doing is counterproductive, but that their child "forces" them to do or not to do certain things. We then start discussing the transfer of power back to the parents.

Clearly, the optimal way of performing family therapy is with face-to-face sessions. The more traditional method allows the therapist to "read" everyone's nonverbal cues such as facial expressions or body language (i.e., posture), not just the adolescent's. However, despite these disadvantages, teleconferencing family therapy sessions have proved helpful when necessary in the residential setting.

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Focus On Support Groups:

Fort Lauderdale Support Group is a "Safe Place"

By Bruce M. Hyman, Ph.D., LCSW
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The Fort Lauderdale, Florida adult OCD support group was started in 1991 by a businessman and long-time OCD sufferer, who, after viewing an "Oprah Winfrey Show" on the subject of OCD, sought medication and cognitive-behavior therapy, both of which had a profoundly positive effect upon his life-long symptoms. His remarkable recovery moved him to reach out to other sufferers; this is how the OCD support group in Fort Lauderdale was formed. Originally held in the doctors' cafeteria at a local hospital, it has since moved twice and is presently held in the conference room of the 9 Muses Center, an art gallery and frame shop devoted to the art and cultural enrichment of the mentally ill in our community.

The group was originally conceived as a place where OCD patients, their partners and family members can feel safe talking about the day-to-day struggles with the disease openly and frankly, without shame, judgment, or embarrassment. It is this vision that has guided the group to this day, and contributed to its ongoing success. Fifteen years later, the group is still running strong and only misses meetings because of bad weather or a national holiday.

The group is open to anyone over the age of 18 with OCD or related spectrum disorders, such as, trichotillomania or Body Dysmorphic Disorder (BDD). Family members and partners of patients are encouraged to attend, even if the patient does not wish to be involved because the guidance and support can be invaluable. Unlike some other sup-

port groups, patients and family members/partners meet together in one group. Our group is typically attended by 15-25 members; and we've had meetings that have had 30 attendees or more. Especially high attendance may occur following a significant OCD story appearing in the media, such as "The Oprah Show."

Adequate attendance is not a problem due to the long, established presence of the group in our community and the fact that it is well-known by the local mental health professionals and allied health workers.

Another important factor has been continuous active community media promotion. It is unlikely the group would have achieved such success without a consistent presence on the Internet (via e-mailists and mental health related websites, such as, www.ocfoundation.org and www.adaa.org) and through the use of free classified advertising on local community cable TV and in the local print media, which regularly lists available free support groups in the community.

Originally conceived as a recovered-patient, peer-run group, the group has benefited from the consistent presence of a "professional adviser," namely, this writer, who frequently takes the reins and runs the group. This form of dual leadership has a number of advantages and has no doubt contributed to its longevity. A recovered patient/peer leader serves as a positive role model of optimal management of the disease, which is invaluable to the newly diagnosed sufferer. Having a leader who is "one of us" encourages openness and honest sharing. The presence of the professional adviser contributes a calm, steady authoritative presence that keeps the group discussion on track, rapidly clears up misconceptions about the disorder and its treatment,

and lessens digression into areas unrelated to OCD. Also, the cultivation of shared leadership within the group means that there is always an effective leader available to run the group in the event that one leader cannot be present.

The format of the group has remains virtually unchanged since its beginning. The group meets twice per month and starts promptly at 7:30 pm, and has no arbitrary ending time. Rather, it ends when all attendees have had a chance to share, whenever that occurs. It is not uncommon for the group to end after 10:30 or 11:00 pm. Each group session typically begins by a welcoming of the attendees by the leader and the ground rules of the group are recited.

The ground rules are as follows: a strict code of confidentiality and mutual respect must be observed by all; a 10-minute time limit on sharing which must be limited to the topic of OCD and its challenges; gossip about group goings-on outside the group is discouraged; there is to be no cross-talk while a member shares, and cell phones and pagers must be silenced throughout the meeting. No attendee is required to speak; sometimes listening can be as valuable as speaking up. But new attendees are encouraged to eventually find the courage to open up and share when they are ready to.

Another important, recently instituted ground rule is that while general discussions of the risks and benefits of medication treatment for OCD is acceptable, discussion of specific medications are prohibited. OCD patients are profoundly affected by the treatment experiences of other patients, and the mere mention of specific medications either helping or not helping only results in more anxiety, confusion, and ultimately undermines the physician/patient relationship. While initially met by protest from some long-standing members, this ground rule has worked well to keep the overall discussion from being sidetracked by needless, even voyeuristic, comparisons of medica-

tions. More constructively, the group reinforces the need for medication compliance and encourages open patient/physician communication about progress and side effects.

After the ground rules are read, we “break the ice” by going around the room and have each attendee identify him/herself by first name. The leader then asks for who wishes to start and the sharing begins. We then move clockwise or counterclockwise from person to person until all attendees have either shared or passed. Those members who pass are encouraged, once they are ready, to share. We will go back to them before the meeting ends.

The most essential positive force within the group is the power of empathy and the commitment of the leaders that the group be a positive place for change and growth. Sharing openly by members in a “safe space” is the vehicle for such change and growth. Our newest members will share, often in the most heartfelt and anguished manner, the challenge of having OCD and the havoc it wreaks in their and their loved ones’ lives. Attendees listen with rapt attention to these stories. This is ultimately empowering, even healing. To hear from a stranger the same anguish, the same embarrassing quirks and symptom manifestations as one’s own provides a profound sense of release from the pain of shame and isolation. Just to know someone else has walked down the painful road of OCD, understands and will not judge you for your struggles, is a powerful source of relief and hope. Our veteran recovered members generously share their stories of recovery with the newer members. The group operates on the belief that the more stable, recovered patients and family members should reach out to those new members who are more severely impaired and in the early stages of treatment. The experiences of those who are much further along in the “journey” toward recovery are a vital source of hope and encouragement to those more severely impaired.

Family members, especially married couples, are particularly encouraged to attend so that the group has a few “stalwart” regularly-attending couples with one recovered spouse/partner, who exemplify optimal couple functioning with OCD. These partners without OCD typically have taken steps to be well-informed about their partner’s OCD problem, and they demonstrate qualities of compassion, patience, acceptance and tolerance toward their partner. They often serve as role models for the more conflicted, more symptomatic couples just entering the group for the first time.

The role of cognitive-behavior therapy, especially exposure and response prevention (ERP), in the treatment of OCD and its day-to-day management is an important backdrop to discussions of the challenges posed by OCD. Most patients attending the group eventually become aware of the principles of ERP through self-help books or other resources. Hearing patients describe how they implement ERP in their daily lives is one of the most useful “pearls” sufferers come away from the group with. Daily victories over OCD, even small ones, are often greeted with praise, even applause. On the other hand, persistent “whining,” complaining, and verbalized “victim-hood” about having OCD without taking proactive steps to address or remedy it constructively, is not tolerated. However, through firm but compassionate coaxing by group members, those “stuck” members are often moved to take the first constructive steps toward confronting their OCD problem by seeking appropriate treatment. The group members are often a good source of information about who are the most qualified professionals treating OCD in the community.

Over the course of many years now, the Fort Lauderdale Support Group has seen hundreds of people with every conceivable form of OCD come and go and has played a role in the progress and recovery of many of

them. Support group attendance is often the catalyst for major positive changes in the sufferer’s OCD; and it is also responsible for improving the understanding of family members confronted with this extremely perplexing and often trying disorder. It is our hope that through the commitment of its leaders and attendees, the group will continue to be an important community resource. And while it is most gratifying to see just how many have benefited, it is sobering to realize that in a region of over four million people, there are so few OCD support groups.

I believe that support groups might proliferate if more local mental health professionals with expertise in OCD became involved in establishing and maintaining them. I personally have found that the involvement with the Fort Lauderdale OCD Support Group is one of the most gratifying experiences of my 22 year career as a psychotherapist. Beyond the fact that the support group has been a steady source of new patients seeking services from my center, involvement in the group has given me the opportunity to “give back” to the community in a way that has truly made a positive difference in the lives of those who attend the group. I would recommend to any mental health professional wishing to establish him/herself as a resource for OCD sufferers in your community to consider starting an OCD support group. There are many sources of information about how to establish and maintain a support group, such as, past articles in the OCD Newsletter. For more information on starting a support group, call Patricia Perkins at the OC Foundation at (203) 401-2074.

Bruce M. Hyman, Ph.D., LCSW, is the director of the OCD Resource Center of Florida located in Hollywood, Florida, (www.ocdhope.com) and co-author of “The OCD Workbook – Your Guide to Breaking Free from OCD,” 2nd Ed., published by New Harbinger Publications. He can be reached via email at ocd-hope@bellsouth.net.

Research Digest

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

Repeated checking really does cause memory distrust

Behaviour Research and Therapy, 44:305-316, 2006, A.S. Radomsky, P.T. Gilchrist and D. Dussault

This study provides evidence why compulsive checking behavior is counterproductive. Repetitive checking leads to memory distrust and this in turn promotes continued and/or renewed checking, which leads to even less memory confidence. College students (n=50) were asked to repeatedly turn on, turn off and check either a real kitchen stove (relevant checking) or a real kitchen faucet (irrelevant checking) in a ritualized manner. Following repeated relevant checking (checking the stove), participants reported significantly reduced memory confidence, vividness and detail. Researchers suggest that educating OCD patients about the negative effects of repeated checking would likely be helpful in motivating individuals to reduce their checking behavior, i.e., to do "ritual prevention," one of the essential elements of cognitive-behavioral therapy (CBT) for OCD.

Treating OCD in patients with psychiatric comorbidity: how to keep anxiety, depression, and other disorders from thwarting interventions

Current Psychiatry, 4(4):57-58,61,65-66,68, 2005, P.S. Wiegartz and S. Rasminsky

It is common for individuals with OCD to also suffer comorbid (co-occurring) disorders. Authors review the prevalence and treatment of comorbid mental disorders. Following are the estimated prevalences of common psychiatric comorbidities found in different studies: personality disorders, 63%; major depressive disorder, 28 to 31%; simple phobia, 7 to 48%; social phobia, 11 to 16%; bipolar disorder, 15%; eating disorders, 8 to 13%; alcohol abuse, 8% (interestingly the only comorbid condition lower than that found in the community [12%]); panic disorder, 6 to 12%; and Tourette's syndrome or tic disorders, 6 to 7%. Suggestions are made for treating OCD with comorbid disorders, as treatment success may depend on identifying and addressing comorbidities. Foremost, conditions that endanger the patient are the priority, i.e., risk of suicide or self-mutilating behaviors. In most cases, behavior therapy using exposure and ritual prevention and medication therapy with serotonin reuptake inhibitors (SRIs) are the first-line treatments, requiring only slight modification with most comorbidities.

Prevalence of irritable bowel syndrome in obsessive-compulsive disorder

CNS Spectrums, 11:21-25, 2006, P.S. Masand, N.J. Keuthen, S. Gupta et al.

Irritable bowel syndrome (IBS) is a common disorder, occurring in 10% to 22% of adults, and even more frequently in patients with anxiety and mood disorders. Diagnosis of IBS requires at least 3 months of continuous or recurrent symptoms of abdominal pain, bloating and disturbed defecation (constipation, diarrhea, or alternating bowel symptoms). Serotonin is involved in the physiology of both IBS and OCD. This study found that 35% of patients with OCD met criteria for IBS in contrast to 2.5% of the control subjects (individuals not having mental disorders). Interestingly, patients had not complained of IBS symptoms until specifically asked in interviews. Most of the patients with IBS suffered both diarrhea and constipation at different times. As IBS occurred in over one-third of these patients, researchers suggest gastrointestinal symptoms should be assessed before treating OCD, as knowledge of preexisting IBS symptoms may guide medication choice, monitoring of side effects, and medication dosing schedules.

Comorbidity of obsessive-compulsive disorder and attention-deficit/hyperactivity disorder in referred children and adolescents

Comprehensive Psychiatry, 47:42-47, 2006, G. Masi, S. Millepiedi, M. Mucci et al.

In this study, 24 (25.5%) of 94 children and adolescents with OCD were also diagnosed with attention-deficit/hyperactivity disorder (ADHD). A comparison was made between two groups, those with ADHD (24 patients) and those without ADHD (70 patients). In the group having both ADHD and OCD there was a higher number of males, an earlier age of onset of OCD, a greater overall impairment in functioning, and a higher occurrence of additional disorders, mainly bipolar disorder, tic disorder, and oppositional defiant disorder/conduct disorder. The overall appearance of OCD, specific obsessions and compulsions, were not affected by ADHD comorbidity. The onset of ADHD preceded the onset of OCD in all children. Importantly, when ADHD was comorbid, the improvement at a 6-month follow-up was lower.

Adulthood outcome of tic and obsessive-compulsive symptom severity in children with Tourette syndrome

Archives of Pediatrics & Adolescent

Medicine, 160:65-69, 2006, M.H. Bloch, B.S. Peterson, L. Scahill et al.

Tourette syndrome (TS) is a disorder frequently co-occurring with OCD. It is characterized by tics (quick seemingly involuntary movements) or vocalizations (verbal outbursts or sounds) that occur repeatedly. In TS, tics typically begin at age 5 or 6, reach a peak severity between 10 and 12 years of age, and substantially decrease or end in late adolescence. These researchers studied the course of tic and OCD symptoms in 46 children with TS through a follow-up interview an average of 7.6 years after the initial assessment. OCD symptoms occurred in 41% of these patients. A majority of subjects (85%) reported a reduction in tic symptoms during adolescence. Tics typically diminished in severity even for those children who had relatively severe tic symptoms. The average age at worst-ever tic severity was 10.6 years. Worst-ever OCD symptoms occurred approximately 2 years later than worst-ever tic symptoms. OCD symptoms in children with TS were more likely to persist than tic symptoms. Increased childhood IQ (intelligence) was associated with increased OCD severity at follow-up.

Comorbid depression in obsessive compulsive disorder (OCD): symptomatic differences to major depressive disorder

Journal of Affective Disorders, 87:327-330, 2005, N.A. Fineberg, H. Fourie, T.M. Gale et al.

Individuals with OCD frequently suffer from comorbid depression and it is often the depressive symptoms for which patients first seek treatment. Depression symptoms are compared between 52 patients with OCD and comorbid depression and 52 patients with major depressive disorder (MDD). The two groups were matched for a similar severity of depression. This study found differences between the depressive symptom profile of OCD patients with comorbid depression and that of MDD patients. The OCD with depression group had significantly more inner tension symptoms and pessimistic thoughts than the group with MDD. The OCD with depression group had significantly fewer sleep problems and appetite disturbances than the group with MDD. Some depressive symptoms were common to both groups, such as depressed mood, poor concentration, low energy, lack of interest and suicidal ideation. These findings are discussed in relation to the neurobiology of OCD and depression.

Update on A Spectrum Disorder: Body Dysmorphic Disorder

by *Elana Golan*
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Body dysmorphic disorder (BDD) is a mental illness characterized by an intense preoccupation with an imagined defect or slight imperfection in one's appearance. This preoccupation can become overwhelming and lead to significant distress and impairment in one's social life, relationships, employment, schoolwork, and overall functioning.

BDD is a fairly common disorder, and is seen in approximately one to two percent of the population, or nearly five million Americans. The disorder is diagnosed equally among men and women. BDD can develop at any age, though it usually appears in early adolescence and, if left untreated, often becomes chronic. In more extreme cases, BDD may result in hospitalizations or suicide. Despite its prevalence, BDD is generally not well known or understood by physicians, friends, family members, the general public, or even by the sufferers themselves.

Any body part can be the focus of a BDD sufferer's preoccupation, though there are particular body parts that are more commonly found to be of concern to BDD patients. People with BDD often agonize about skin color, acne, wrinkles, scars, facial asymmetry, and thinning or excessive hair. Other frequent issues of concern may be the shape or size of the nose, eyes, mouth, lips, or teeth. Muscle dysmorphia is a subtype of BDD that primarily impacts men. Muscle dysmorphic individuals believe they are not strong or muscular enough and respond with excessive exercise, at times to the point of joint injury or steroid abuse.

BDD can be difficult to diagnose and may be mistaken for a number of other disorders, including obsessive-compulsive disorder (OCD), major depression, social anxiety disorder, or an eating disorder, among a number of other conditions. Diagnoses are made even more challenging by the fact that BDD individuals are often secretive, embarrassed, or ashamed of their symptoms

and, thus, frequently opt not to reveal their distress to family, friends, or physicians. Many BDD patients believe their imagined flaw to be real and will often seek medical treatment as opposed to psychiatric care for their problems. Given these factors, it is vital that physicians in other medical fields, not only in mental health, learn how to properly distinguish between a patient with normal appearance concerns and one whose worries are unreasonable and to refer those with excessive concerns for the appropriate treatment.

How can you determine if an individual has BDD?

BDD sufferers frequently visit plastic surgeons, dermatologists, and dentists, seeking treatment for their perceived flaws. They exhibit an array of symptoms, including:

- Maladaptive appearance-related thoughts and distorted beliefs. (i.e., "If my appearance is not perfect, I am worthless." or "I must look amazing in order to be happy.")
- Unrealistic perceptions and expectations of their own appearance. Low self-esteem.
- Repetitive behaviors designed to check or correct their imagined flaw, such as mirror checking, grooming, skin picking, or hair pulling.
- Reassurance seeking.
- Comparing their appearance unfavorably to that of others.
- "Doctor shopping." People with BDD have often had countless cosmetic surgeries or other procedures to correct their perceived imperfections and are often unsatisfied with the results.
- Avoidance behaviors. Sufferers may avoid mirrors or bright lights. They may hide or camouflage the body part of concern with cosmetics or clothing, or by altering their body position. Sufferers may engage in repetitive or avoidance behaviors for several hours every day, but this seldom provides more than temporary relief.

To be diagnosed with BDD a person must spend at least one hour per day thinking about the perceived imperfections in his or her appearance, though on average, BDD individuals spend

between three and eight hours per a day preoccupied with such thoughts. Research suggests that approximately 7 to 15 percent of cosmetic surgery patients and 12 percent of dermatological patients actually suffer from BDD, (Phillips, K.A., Castle, D., 2001). Many sufferers seek a medical diagnosis, which confirms their belief that they have a physical problem and further obscures the psychiatric basis of their concern.

Despite the severity of BDD, a number of medications and psychotherapeutic treatments have been shown quite effective in significantly reducing the symptoms of the disorder. In recent years, cognitive-behavioral therapy (CBT) has grown increasingly popular as a form of treatment for BDD and has demonstrated impressive results when administered in either an individual or group setting. CBT combines various cognitive and behavioral treatment strategies. By combining these treatment elements into CBT, we can better target the multiple issues, challenges, and complications faced by someone with BDD.

Another treatment option is pharmacotherapy. Recent research has shown the effectiveness of a certain group of antidepressants known as selective serotonin reuptake inhibitors (SSRIs) in treating BDD, even for those individuals who are delusional. Successful medication treatment can result in a reduction in time spent focused on one's appearance, less time spent on associated ritualistic behaviors, less agony and distress, and a decrease in depressive symptoms. Patients often develop better insight into their BDD problems. An individual with BDD should be on a medication for 12-16 weeks before assessing his/her response to the drug. If one SSRI is found ineffective, another should be attempted. Medication may be used alone, though patients who take medication as an adjunct to CBT appear to improve most significantly.

Self-help books for BDD are also available. Dr. Sabine Wilhelm, an Associate Professor of Psychology at Massachusetts General Hospital and Harvard Medical School, has recently written a new book, *Feeling Good About the Way You Look: A Program for Overcoming Body Image Problems*, which contains invaluable

GUIDELINES FOR

The following is an excerpt from "Learning To Live With OCD" (Van Noppen, Pato, Rasmussen and Boudouvas), a booklet published by the OC Foundation, which will be released in its 6th edition this year.

Families are constantly affected by the demands of OCD. Results from research investigating family and OCD suggest that family responses may play a role in maintaining or even facilitating OCD symptoms. The more that you can learn about family responses to OCD and the impact that these responses have on the person with OCD, the more you and other family members become empowered to make a difference!

Responses of families to the person with OCD vary. There are five typical responses: 1) families who assist with the rituals and encourage avoidance (do things for the person with OCD) to keep peace, 2) families who do not participate in them but allow the compulsions, 3) families who refuse to acknowledge or allow the compulsions in their presence, 4) families who split in their responses - some family members giving in all the time and some refusing to, and 5) families whose members swing from one extreme to the other, trying to find the "right" solution. In any case, extreme and/or inconsistent family responses create more feelings of frustration and helplessness as the OCD symptoms seem to increase.

Family members who take over roles and participate in or assist with compulsions tend to become emotionally over-involved, often neglecting their own needs and at the same time fostering the cycle of obsessions and compulsions. On the other hand, those family members who express hostile criticism by labeling the person as "crazy" or telling him/her to "just snap out of it" may be perpetuating symptoms as well. Research has found that some criticism of the OCD symptoms that is not directed toward the person can be a useful motivator and may help the person with OCD face his/her fears, consistent with exposure-based therapy. The rules of OCD cannot become everyone's reality. It is hard to find this fine line between setting limits to the effect OCD has on the family and expressing support and empathy for the person afflicted. OCD is a family affair and the sooner you can learn to respond in more therapeutic ways, the better everyone will feel as recovery begins.

The natural tendency to put the warning signs of OCD aside seems to prolong seeking professional help. As more is learned about OCD, one can be more optimistic about treatment and recovery.

In an effort to help families, the following list of guidelines has been developed by family members and people with OCD who have experienced the difficulty in coping first hand.

General Guidelines for family members:

1. Learn to recognize the signals that indicate a person is having problems.
2. Modify expectations during stressful times.
3. Measure progress according to the person's level of functioning.
4. Don't make day-to-day comparisons.
5. Give recognition for "small" improvements.
6. Create a strong supportive home environment.
7. Keep communication clear and simple.
8. Stick to a behavioral contract.
9. Set limits, yet be sensitive to the person's moods.
10. Keep your family routine "normal."
11. Use humor.
12. Support the person's medication regime.
13. Realize that separate time for other family members is important.
14. Maintain flexibility throughout the family!

Recognize Signals

The first family guideline stresses that family members recognize the "warning signals" of OCD. Sometimes people with OCD are thinking things you don't know about as part of the OCD, so watch for behavioral changes. This list of 12 signals is by no means exhaustive. Do not dismiss significant changes as "just their personality." Remember changes can be gradual; but overall, they reveal differences from how the person generally has behaved in the past. When asked to list behaviors noticed as changes or peculiarities that begin to interfere with someone's social and/or occupational functioning, families commonly report noticing unexplained blocks of time that the person is spending alone (in the bathroom, getting dressed, doing homework), avoidance, irritability, indecisiveness. These behaviors can be easily mistaken for laziness or manipulation. It is essential that you learn to view these features as signals of OCD, not personality traits. This way, you can join the person with OCD to help combat the symptoms, rather than become alienated from the OCD sufferer. People with OCD usually report that the more they are criticized or blamed, the worse the symptoms get!

Signals to watch for include:

1. Large blocks of unexplained time.
2. Doing things again and again - repetitive behaviors.
3. Constantly asking for or needing constant reassurance.
4. Simple tasks taking longer than usual.
5. Perpetual tardiness.
6. Increased concern for minor things and details.
7. Severe and extreme emotional reactions to small things.
8. Inability to sleep properly.
9. Staying up late to get things done.
10. Significant change in eating habits.
11. Daily life becomes a struggle.
12. Avoidance.

Modify Expectations

Consistently, people with OCD report that change of any kind (even positive change) is experienced as stressful. It is during those times that symptoms flare. Along with being able to identify OC symptoms, you can help to moderate stress by modifying your expectations during times of transition. Instead of projecting a frustrating "Snap out of it!" message, a statement such as: "No wonder your symptoms are worse, look at the changes you are going through," is validating, supportive, and creates a positive alliance. Further, family conflict only fuels the fire and promotes symptom escalation. It helps to be flexible with the behavioral treatment program during stressful times.

People Get Better at Different Rates

The severity of OC symptoms is a continuum. Severity is usually rated by the degree of emotional distress and the degree of functional impairment. There is a wide variation in severity of symptoms between individuals. You should measure progress according to the person's own level of functioning, not to that of others. You should encourage the sufferer to "push" himself as much as possible, to function at the highest level possible. Yet, if the pressure to function "perfectly" is greater than a person's ability, it creates another stress which leads to more symptoms. For example, you may have observed differences among OCD sufferers and have made comments (or thought): "Well, if that person can uphold family responsibilities and work, why can't you?" This may be an unreasonable

L I V I N G W I T H O C D

expectation given an individual's pattern or course of illness. Just as there is a wide variation between individuals regarding the severity of their OC symptoms, there is also wide variation in how rapidly individuals respond to treatment. Be patient. Slow, gradual improvement may be better in the end if relapses are to be prevented.

Avoid Day-To-Day Comparisons

Often sufferers feel like they are "back at the start" during symptomatic times. You may have made the mistake of comparing your family member's progress with how he functioned before developing OCD. Due to the "waxing and waning" course of OCD, it is important to look at overall changes since treatment began. Day-to-day comparisons are misleading because they don't accurately reflect improvement. Help the person to develop a realistic "internal yardstick" to measure progress. On the days that the sufferer "slips," you can remind him that "tomorrow is another day to try," so that the increased rituals won't be interpreted as failure. Feeling as though one is a failure is self-destructive; it leads to feeling guilty and feeling "imperfect." These distortions create stress which can exacerbate symptoms and lead to feeling more "out of control." You can make a difference, if you remind the sufferer of how much progress he has made since the worst episode and since beginning treatment.

Recognize "Small" Improvements

People with OCD often complain that family members don't understand what it takes to accomplish something such as cutting down a shower by five minutes or not asking for reassurance one more time. While this may seem insignificant to family members, it is a very big step for them. Acknowledgement of these seemingly "small" accomplishments is a powerful tool that encourages the person with OCD to keep trying. This lets the sufferer know that his hard work to get better is recognized by you. Verbal praise is a strong positive reinforcer. Don't hesitate to use it!!

Create A Supportive Environment

The more you can avoid personal criticism, the better. It is the OCD that gets on everyone's nerves. Try to learn as much about OCD as you can. Your family member still needs your encouragement and your acceptance of him as a person. Remember that acceptance and support does not mean ignoring the compulsive behavior. Do your best not to participate in the compulsions. Without hostility, explain that the compulsions are symptoms of OCD and that you won't help because you want the sufferer to resist. This projects more of a non-judg-

mental attitude that reflects acceptance of the person.

Keep Communication Clear and Simple

Avoid lengthy explanations. This is often easier said than done, because most people with OCD constantly ask those around them for reassurance: "Are you sure I locked the door?" "Can I be certain that I cleaned well enough?" You have probably found that the more you try to prove that the sufferer need not worry, the more he disproves you. Even the most sophisticated explanations won't work. There is always that lingering "what if?"

Stick To A Behavioral Contract

In your efforts to help the sufferer reduce his compulsions you may easily be perceived as being "mean or rejecting," although you are trying to be "supportive." It may seem obvious that family members and sufferers are working toward the common goal of symptom reduction, but the ways in which people do this varies. First, there must be an agreement between family members and sufferers that it is in the sufferer's best interest for the family not to participate in rituals (this includes responding to incessant requests for reassurance). It is ideal for both family members and sufferers to reach this agreement. Often attending a family educational support group for OCD or seeing a family therapist with expertise in OCD facilitates family communication. As a general rule, short, simple responses are best.

Set Limits But Be Sensitive to Mood

With the goal of working together to decrease compulsions, family members may find that they have to be firm about: 1) prior agreements regarding assisting with compulsions, 2) how much time is spent discussing OCD, 3) how much reassurance is given, and, 4) how much the compulsions infringe upon others' lives. It is commonly reported by sufferers that mood dictates the degree to which the sufferer can divert obsessions and resist compulsions. Likewise, family members have commented that they can tell when the sufferer is "having a bad day." Those are the times when family may need to "back off," unless there is potential for a life-threatening or violent situation. On "good days," sufferers should be encouraged to resist compulsions as much as possible.

Keep Your Family Routine "Normal"

Often families ask how to "undo" all of the effects of months or years of going along with obsessive-compulsive symptoms. For example, to "keep the peace" a husband allowed his wife's contamination fear to

prohibit their five children from having any friends visit the household. An initial attempt to avoid conflict by giving in just grows. Obsessions and compulsions must be contained. It is important that children have friends in their home or that family members use any sink, sit on any chair, etc. Through negotiation and limit-setting, family life and "routines" can be preserved. Remember, it is in the sufferer's best interest to tolerate the exposure to his fears and to be reminded of others' needs. As he begins to regain function, his wish to be able to do more increases.

Use Humor

The ability to distance oneself from irrational fears and laugh is healthy, especially when done in company. Both family members and sufferers report this to be a relief. Again, sensitivity to the sufferer's mood should be considered before gently poking fun at the OCD. Although humor has been recognized for its healing properties for ages, it may not be best to joke when the OC symptoms are acute.

Support The Medication Regime

Always check with the physician about questions, side effects, changes that you notice. Don't undermine the medication instructions the physician and/or clinical professional have given.

All medications have side effects that range in severity. Some are very bothersome (dry mouth, constipation, sexual dysfunction). Discuss these with the treating physician and evaluate the risks and benefits.

It should be noted here that for people who cannot pay for medication, it can be obtained at a reduced fee through a special program for OCD medication. The treating psychiatrist can request a copy of the guide by calling 1-800-PMA-INFO.

Assure Separate Time for Everyone

Often, family members have the natural tendency to feel like they should protect the sufferer by being with him all the time. This can be destructive because family members need their private time, as do sufferers. Give the sufferer the message that he can be left alone and can care for himself. Also, OCD cannot run everybody's life; you have other responsibilities besides "babysitting."

Be Flexible

Above all, these are guidelines! Always consider the severity of the OC symptoms and the sufferer's mood as well as level of stress when making decisions about enforcing limits. Be reasonable, and try to convey caring in your actions.

Training Parents to Become Therapists

By *Eda Gorbis, Ph.D., MFT*
 Director, Westwood Institute for Anxiety Disorders, Inc.

Assistant Clinical Professor, UCLA
 Neuropsychiatric Institute and Hospital
 Los Angeles, California

Jenny C. Yip, Psy.D.
 Assistant Research Director
 Westwood Institute for Anxiety Disorders, Inc.

It cannot be stressed enough – involving parents and other caretakers in the treatment of children and adolescents with obsessive-compulsive disorder (OCD) is absolutely necessary. This is also essential for those adults with OCD who continue to live with and depend upon their parents.

OCD typically involves other family members of the patient suffering from this disorder. It significantly interferes with family dynamics and has a significant impact on family functioning. In addition, families play a critical role in the patient's treatment readiness, compliance, recovery rate, and relapse. Thus, consideration of the familial context, developing healthy collaborative relationships among the patient, his/her family, and the therapist, and integrating the family into treatment are vital to treatment outcome, since families are an integral part of the lives of individuals with OCD.

The level of involvement families take in the patient's rituals varies. However, a family's affect level can influence and is influenced by OCD. For instance, a calm supportive family may improve the outcome of OCD treatment, whereas a family that is excessively critical and over-involved may exacerbate the symptoms in the patient. It is crucial to assess family dynamics such as these accurately in order to treat OCD successfully. It is necessary at a minimum that one of the parents or a caretaker is present throughout the treatment process, especially during the initial assessment. This allows the patient, parent, and therapist the opportunity to explore the individual's subjective experience of OCD, as well as specific symptoms and underlying fear structures.

Following a thorough and comprehensive assessment of the patient's obsessive fears, compulsive behaviors, and the family's level of involvement in the patient's rituals, comes the crucial task of psychoeducation. The purpose of educating the family is to provide a cognitive-behavioral framework for OCD, and to explain the treatment process. To ensure that the sufferer is significantly motivated and the treatment will be successful, the most important thing is that each family member understands how OCD functions within the context of the

family, and how the family as a whole can defeat OCD.

Learning about OCD and its symptoms is an important first step in understanding how to defeat it. Mrs. Smith,* mother of a 19-year-old adolescent who was successfully treated five years ago in our intensive treatment program, states, "Families really need to be involved in treatment, because they really do play a part in OCD even when they don't realize it. Whenever I had company over, I didn't know they were all contaminating the whole house for my son."

The family must learn such key concepts as the vicious cycle of OCD, the OCD triangle, the overappraisal of threat, harm, and danger in obsessive fears, the physiological law of habituation to a feared response, and the various cognitive errors resulting in the interpretation of intrusive thoughts to have meanings of threat, harm, and danger.

Once the family understands how it functions within the patient's OCD cycle, family members must agree not to partake in any part of the patient's ritualistic behaviors. For instance, a child with OCD probably has tried to control his/her ritualistic handwashing behavior, as well as those of other family members. Many pathological doubters seek reassurances from their parents, or ask their siblings to check door locks, stoves, cleanliness of objects, etc., more often than necessary. These repetitive behaviors often irritate those who are pulled involuntarily into the vicious cycle of OCD. In order to reduce their own frustration, family members may give in to the OCD by complying with his request, which, in turn, only reinforces the obsessions and rituals.

When a patient insists on involving another in his/her ritualistic behavior or reassurance seeking, the rule of thumb for the involved family member is to always courteously respond with: "It's the OCD asking." Not only can family members detach themselves from the rituals of OCD by identifying the behavior as "OCD," this response also helps the patient separate him/herself from the OCD. Many OCD sufferers have come to identify themselves as merged with the disorder. Accordingly, Mrs. Smith affirms, "Once I understood that I was actually contributing to my John's* OCD, I was able to tell him that 'it's your OCD that's asking me,' which also took the burden off my shoulders."

In helping the patient manage specific obsessions and compulsions, the family must also learn the basic principles of Cognitive-Behavioral Therapy (CBT) and,

more specifically, Exposure and Response Prevention (ERP), which are the most effective methods for treating OCD. The purpose of exposure is to reduce the anxiety and discomfort associated with obsessions through a process called habituation. Habituation is the natural process by which our nervous system gets "used to" or "bored by" feared stimuli through repeated and prolonged contact.

There are two types of exposures: *in vivo* and imagery. *In vivo* or "real life" exposures require the patient to confront his/her fears in the flesh. For instance, a child may be asked to touch feared objects, such as an empty trash can or other "contaminated" objects, without alleviating the anxiety with handwashing compulsions. Through repeated practice, the patient realizes that the feared catastrophic consequence does not occur, and the initial anxiety associated with the feared situation decreases. Exposures are conducted according to hierarchical stages, in which components of anxiety are broken into smaller pieces. We call them baby steps.

Sometimes it is impractical or impossible to create the actual feared situation. An example of this is the fear of developing a disease or losing a loved one. In these situations we utilize imagined exposures, which involve prolonged and repeated visualizations of the feared image or situation along with the experience of anxiety. Variations of different scripts of imagery tapes are made and tailored to the individual's needs and fear structures, which are then replayed continuously until the patient habituates to them.

In order for the family to understand the basics of CBT and specifically ERP, the family must be present and involved during the exposure exercises. The purpose of having family members present and involved is to help them learn the tools necessary to manage obsessive-compulsive symptoms upon termination of treatment.

In essence, the goal is to train family members to become therapists themselves, which also serves two other purposes. First, in order to know how to deal with OCD, one must be able to accurately identify the symptoms of OCD, which requires mindfulness. Mindful awareness training is part of CBT and a necessary component to treatment success. Second, since children tend to resist exposure exercises due to the discomfort they create, being present and involved will reduce manipulations that the child may engage in. As Mrs. Smith clearly confirms, "...being involved (in treatment) forces the child into accountability and keeps him from manipulating. John

* Names changed to protect the privacy of the family involved.

was willing to protect OCD at all cost."

In addition to the above guidelines for the family, the following coping strategies should be adopted:

- Don't take OCD upon yourself. Separate self and family from OCD.
- Know others are out there. You are not alone. Connect with other family members for support and encouragement.
- Be cool! Use a calm manner. Reacting in frustration and distress only leads to further frustration and distress.
- Always speak clearly, calmly, and in a positive way.
- Adjust expectations realistically to reflect current circumstance. Never compare your child's progress to anyone but him/herself.
- Encourage your child to put extra energy into enjoyable activities (i.e., exercise, listening to music, etc.).
- Redirect your own energy into enjoyable activities rather than being a slave to your child's OCD.
- Identify rituals and compulsions for what they are, rather than participate in them.
- Go about your own business as usual. Reconnect with friends, hobbies, and family routines.
- Never be judgmental of your child's behavior.
- Never make decisions for your child (unless it's a young child). Help your child build confidence by allowing the patient to make his/her own choices.
- Do not pressure the patient to stop compulsions or restrict rituals. Just stick to tasks assigned by the therapist.
- Set the rules, limits, and boundaries clearly, and make certain the patient fully understands them.
- Solve problems step-by-step. Make changes gradually. Work on one thing at a time.

Teaching and learning are the main pillars on which our success stands, and we believe that emphasizing success and building upon it will build more success. Knowledge is power. If there is a silver lining to OCD, it is that sufferers still have insight, allowing them to be more aware of the present. We must learn from our interactions with each other, as students and teachers, children and parents, patients and therapists. "The best is for families to understand that it's going to be tough, but when the child gets better, he/she will be a new person. We got John back. He was covered underneath OCD, and I don't think we could've done it without being involved and learning the tools we have," concluded Mrs. Smith.

Message From the President

Continued from page 1)

both of whom contribute significantly to the growth of the foundation. Carter Waddell, Treasurer of the OCF Board, and Tom Lamberti, Vice President of the Board, are also members of the OCF Finance Committee. These men joined the board when their sons became ill with OCD.

With a BA in Economics and a Masters in Business Administration, Carter brings a wealth of knowledge to the Finance Committee. Carter

is a Senior Vice President in International Banking with JP Morgan/ Chase Bank in Arizona.

Seven years ago, when it was clear that his son had OCD, Carter struggled to find appropriate medical care where his family lived. Fortunately, he sought out the OCF and was provided with an Info Packet on OCD management, treatment, and support. Carter also turned to the OCF web site, specifically the "Ask The Experts" section. It proved to be incredibly helpful. Today his son is a full time student at a major university.

Carter encourages those with a child suffering with OCD to make every effort to attend the Annual Conference with their entire family. From experience, Carter knows that children with Obsessive Compulsive Disorder are confused and frustrated with the illness. He believes that while the conferences are wonderful from an educational standpoint, they are also important for what else transpires. He has personally seen many children making friends with other kids their own age who have OCD. For parents, meeting people who are coping with the same issues makes it easier to confront the many problems that arise.

Tom Lamberti, a partner at Putney,



Tom Lamberti



Carter Waddell

Twombly, Hall & Hirson in New York City, specializes in labor and employment law. He is a graduate of Fordham College and Harvard Law School. Tom is a Trustee of the Village in Garden

City and a member of the Labor and Employment Section of the New York Bar Association. This year Tom is also a member of the Nominating Committee for the OCF Board of Directors.

Tom turned to the Foundation for assistance six years ago when he wanted to learn about the nature of his son's disorder and treatments offered by qualified professionals. Although it was extremely difficult for Tom's son when he was first struggling with OCD, he is now attending McGill University and doing very well.

Both Tom and Carter feel that if someone has Obsessive Compulsive Disorder or has a family member or a friend with OCD, it is beneficial for them to join the Foundation. Through the newsletter that is published six times a year, a member can learn more about the disorder, the treatments and the experts in the field. Tom also feels that if you are able to contribute on a financial level, it will help the organization fund research for a cure, support outreach for public awareness of OCD, and get involved with legislation concerning those with a mental illness.

Tom Lamberti and Carter Waddell continue to give of their time to the OCF Board of Directors and it is a pleasure to work alongside two men who care about the direction of this organization and advances in OCD treatment. Kudos to them for the work they have done.

Best Regards,
Joy Kant
President
OCF Board of Directors

Celebrate

The Foundation's

20th Anniversary

by Giving to the

OCF Research

Fund

Anxiety Disorders Foundation Offers Funds for OCD Treatment at Rogers Memorial

The Anxiety Disorders Foundation (ADF), Inc. is a non-for-profit, charitable organization dedicated to improving the lives of those affected by anxiety disorders. The ADF was founded by Dr. Bradley C. Riemann, Ph.D., who also is the President of the foundation's Board of Directors. Dr. Riemann also serves on the Scientific Advisory Board of the OCF. ADF's mission includes funding treatment for those who cannot afford it, funding training for mental health care providers to spur better assessment and treatment, and increasing public awareness of these conditions.

"The Anxiety Disorders Foundation was created out of a need. Our outpatient clinics in Wisconsin get several calls each week from individuals all over the country who need help but they don't have insurance or can't afford to pay out of pocket for treatment. ADF is attempting to help solve this problem", stated Riemann. "Other organizations, such as OCF do such a great job supporting public awareness and research, but we felt there was a void in directly funding treatment. We believe we are the only organization of this type," Riemann expanded.

To date 100% of funds raised have been allocated to fulfilling the ADF's mission, with zero administrative costs. "We have a very dedicated and passionate board. The board has funded all the development and day-to-day costs which have been substantial. Things like incorporation, letterhead, telephone, brochures, and our web site (www.anxietydisordersfoundation.org) have all come from the board, which leaves funds from outside donors to go directly to treatment scholarships," stated Riemann. Over

the last two years, the ADF has raised nearly \$100,000. Most of these funds have come from the grateful families of those that Riemann and his colleagues have treated in these outpatient clinics.

In the United States, anxiety disorders are the most common psychiatric illnesses. Nineteen million people are afflicted each year and one in four at some point in their lives. Anxiety disorders are not only prevalent in adults, but in the young as well, with an estimated 13% of children ages 9-17 being affected. Anxiety disorders include obsessive-compulsive disorder, panic disorder, generalized anxiety disorder, social anxiety disorder, and post-traumatic stress disorder. Anxiety disorders are also very debilitating. Research indicates that in the U.S. alone, the annual economic burden of anxiety disorders is more than \$60 billion. "The real irony as you know is that anxiety disorders, when handled properly, are very treatable. Overall, success rates of roughly 75% have been found time and time again using cognitive-behavioral therapy (CBT)," Riemann said.

Despite this high rate of success, only a small portion (27%) of anxiety disorder sufferers get the treatment they need. Research points to three reasons for this failure. First, there is still a relatively low level of public awareness regarding anxiety disorders and their treatment. Second, health professionals continue to have difficulties recognizing these conditions in their patients, and third, there is still less than adequate availability of appropriate treatment (i.e., CBT). With regards to the third point, Riemann states, "availability of treatment has been limited by two factors. First, very few CBT centers of excellence exist

nationwide. Second, due to the debilitating effects of anxiety disorders, many sufferers may not get help because of financial considerations. ADF is trying to help both issues through its training workshops and treatment scholarships."

ADF began to provide treatment scholarships last year. It funded 12 patients in 2005. "Most of the recipients were diagnosed as having OCD. In part, because that is what we are most known for, but I also believe because it can be so debilitating. We funded both children and adults. It is really exciting," Riemann said. ADF's goal for 2006 is funding 20 patients. "We hope to continue to grow each year, and help more people. It takes so long just to get up and running, and now we are finally able to start fulfilling our mission," Riemann elaborated.

Treatment is provided by Joan Regnary, M.S., in donated space in Riemann's office at Rogers Memorial Hospital in Oconomowoc, Wisconsin. "Joan has been with me for nearly 10 years. She is a great clinician and has now been hired by ADF to provide all of its scholarship treatment at a dramatically reduced rate," stated Riemann. Scholarships are not limited to individuals from Wisconsin, however. "We are currently talking with a woman from South Africa about coming for treatment. Anyone who is clinically and financially appropriate is eligible, not just people from Wisconsin," emphasized Riemann. "Our ultimate goal would be to fund transportation and lodging as well. Right now we are not able to do that. However, we are just getting started," concluded Riemann. To apply for a treatment scholarship, please call 262-567-6600.

The Latest Behavior Therapy Institute Trains 23 Treatment Providers in L.A.

The OCF recently held one of its Behavior Therapy Institutes in Los Angeles on February 11-13, 2006. This intensive training session was held at the UCLA Neuropsychiatric Institute and the Westwood Institute for Anxiety Disorders, Inc. in Los Angeles. Twenty-three clinicians from various states, and one from Cyprus, attended the 3-day live instruction by BTI faculty members, who are some of the leading experts in the field of OCD. Limited enrollment of attendees allows for an improved interactive environment in which participants were able to exchange ideas and questions constructively. The BTI was designed to be an intensive and comprehensive training program beyond that which is typically provided by traditional workshops. Prior to arriving in Los Angeles for the BTI, participants were instructed to read specific assigned material on the treatment of OCD and to conduct an assessment of an OCD case to be addressed at the BTI. Following the BTI, participants receive three follow-up case consultations by phone from a faculty member.

The objective of the first day of the BTI was to teach participants how to accurately identify OCD and to design and implement cognitive behavioral interventions, especially exposure and response prevention, for OCD. This section was led by Gail Steketee, Ph.D., who addressed the basic principles and techniques in assessing, diagnosing, and treating OCD. Examples of cognitive-behavioral treatment plans and the treatment process for various forms of OCD (e.g., washers, checkers, repeaters, etc.) were illustrated. Dr. Steketee is the Dean and Interim and a Professor at Boston University School of Social Work.

The second day of the program covered special populations and topics

related to OCD. Sanjaya Saxena, MD, Associate Professor of Psychiatry at the University of California, San Diego, reviewed the most recent developments in the pharmacotherapy of OCD and the integration of drug treatment with cognitive-behavior therapy (CBT). During the second half of the morning, special issues associated with the treatment of children and adolescents with OCD and the application of the CBT model to this population were addressed by John Piacentini, Ph.D., Director of the Child OCD, Anxiety and Tic Disorders Program, and Professor of Child Psychiatry at UCLA Neuropsychiatric Institute.

In the afternoon, Eda Gorbis, Ph.D., Assistant Clinical Professor at UCLA Neuropsychiatric Institute and Hospital, and Director of Westwood Institute for Anxiety Disorders, Inc., concentrated on the comorbidity of OCD, treatment implications of the OC Spectrum Disorders, and the modification of the CBT model for these related conditions. OC Spectrum Disorders addressed included Hypochondriasis, Body Dysmorphic Disorder, Eating Disorders, Trichotillomania, Dermatillomania, Onychophagia, Pyromania, Kleptomania, Pathological Gambling, and such neurological disorders as Tourette's Syndrome, Sydenham's Chorea, and Autistic Spectrum Disorders. Alec Pollard, Ph.D., ended the second day with discussions of common practical issues in treating OCD, such as treatment readiness and patient ambivalence and resistance to treatment. Dr. Pollard is the Director of the Anxiety Disorders Center at Saint Louis Behavioral Medicine Institute, and a Professor of Community and Family Medicine at Saint Louis University.

On the third and last day partici-

pants were divided into five smaller groups to address the OCD case that each participant worked up and brought to the program. Attendees received individual consultation on the formulation and treatment planning of their cases from a BTI faculty. Gerald Tarlow, Ph.D., Clinical Professor of Psychiatry and Biobehavioral Sciences at UCLA joined Drs. Steketee, Piacentini, Gorbis, and Pollard on the third day to lead one of the five breakout groups. The purpose of the breakout groups is to give each participant the individual attention necessary for the refinement of each trainee's skill in the cognitive-behavioral model of OCD. This allowed participants the opportunity to increase their ability to develop individualized, comprehensive treatment plans for their patients. The breakout format also permitted participants to learn from the four other individualized case formulations from their group. Participants returned home to their practice prepared to implement the treatment plan specifically developed and tailored for their OCD case. Should questions or challenges arise during the application of the individualized OCD treatment, participants have three individual telephone consultations with their specific BTI faculty group leader. The OCF Foundation awards a certificate of completion to participants upon completion of the phone consultations to the satisfaction of their faculty leader.

**Celebrate the OCF's
20th Anniversary!
Give to the OCF
Research Fund.**

Getting Help For OCD From A Mother's Perspective

It was Thanksgiving Day, 1997, my most favorite holiday! We were driving to our niece's house for our annual family gathering, a day filled with talking, laughing, and, yes, eating, surrounded by the love and warmth of family. I heard my daughter say, "Oh, my gosh, I just saw an 'X' on that license plate. Something terrible is going to happen to us." I thought she was kidding around with her sister, so I went back to grading my math papers (teachers have to make use of spare time). When she repeated herself a short time later, after passing another car with an "X" on the license plate, I became concerned. One month later, after an evaluation by a recommended psychiatrist, my daughter was diagnosed with OCD and some OCD spectrum disorders, and the nightmare began!

It is amazing that she kept so much hidden for so long. How could it be? There was no history that we were aware of in the family. Our daughter was outgoing, funny, a "people person" with the nicest friends, and a very good student. An avid reader since she was a small child, and an excellent writer, she had just graduated from the University of Michigan as an English literature major that past spring. She was working for a small advertising agency in Manhattan while trying to decide if she wanted to pursue advertising, public relations, journalism, or law.

We knew nothing about mental illness, in general, and OCD, in particular. We tried to read about it and to learn, but had limited resources. We live in a suburb of New York where doctors abound. It took us a while to realize that because one is a doctor does not imply that one is an OCD specialist!

The psychiatrist said it didn't make any difference whether our daughter had psychotherapy or cognitive-behavioral therapy. Since there were no behavioral therapists where we lived, she began with psychotherapy once a week. It was not the correct choice! Her paranoia was getting worse. Convinced that her boss was about to fire her, which triggered constant obsessing, she quit her job. Fortunately, she talked her way into a new job as the personal assistant to a local attorney doing paralegal work. She held this job for a year and a half, until her symptoms so intruded on the performance of her work that the attorney was forced to let her go. She got two more jobs after that; the last was making and serving coffee at Starbucks. She was fired from both.

By now, she was severely depressed, had no self-esteem, had given up socializing, and had lost most of her friends. Most days she lay almost "comatose" on her bed. We likened it to the "invasion of the mind and body snatchers." Emotionally, we felt as if someone had stolen our daughter and left us this stranger. After much inquiry, we did find a behavioral therapist, at a distance from us, but whom she saw once each week. We interviewed several new psychiatrists and changed doctors as well.

The despair, the helplessness, my husband, my other children, and I all felt were overwhelming. We felt so alone, with only a few family members and very close friends aware of our situation. Mental illness was still stigmatized and not well understood by most people. The sense of isolation continued to engulf us.

Then, one day, our prayers were answered. I was reading "Dear Abby," the nationally syndicated advice column, in my local paper. A mother had written describing her son's behavior and Abby's response was that it sounded like he might have some OCD symptoms. She strongly suggested that the mother contact the OC Foundation, based in New Haven, CT to learn more about the illness. I was stunned!!! Not one doctor or therapist told us that this organization existed. I immediately contacted the OC Foundation and joined with a family membership. Finally, we began to experience the first rays of sunshine and hope!! For the first time we could see the path, although often bumpy and with some curves, whose final destination was RECOVERY! For the first time, we were no longer alone!

My "LOVE LETTER" begins:

Thanks to the OC Foundation and its hard-working staff, we now have an outstanding resource to which we can turn for questions and concerns. We can order books written to provide knowledge about OCD. The newsletters, with so many informative articles written by top doctors/therapists who are specialists in OCD and the spectrum disorders, keep us well-educated and provide us with insight into what many OCD sufferers experience. These articles have helped us understand the many forms the illness takes, as well as offering suggestions for possible steps to be taken to achieve greater success in mastering the illness. The newsletters keep us abreast of new treatment approaches and programs, either residential or outpatient, as well as the latest research studies.

Thanks to Chris Vertullo (a member of the OCF Board of Directors), who initiated it, the OCD Support Group List exists. It is a huge on-line support group for people with OCD, as well as their family members and friends. It is a place where they can share their problems and feelings with others who understand what they are going through. They can question the experts, Dr. Michael Jenike, a psychiatrist, and Dr. James Claiborn, a psychologist. We need never be alone again!!!!

The OC Foundation sponsors the Behavior Therapy Institute to train mental health professionals in cognitive-behavior therapy so that there are many more professionals around the country who can provide this therapy, which is so critical and necessary in the treatment of OCD. The OC Foundation Research Fund sponsors and supports research projects that I strongly believe will ultimately provide answers and minimize, if not totally eradicate, suffering from this illness. Research is the key and the OC Foundation is the bearer of that torch that will light the way to a brighter future!!

If all that were not enough, the OC Foundation organizes and runs its Annual Conference, bringing together outstanding professionals in the field, presenting workshops and seminars that deal in-depth with all aspects of OCD and the spectrum disorders, workshops for those that suffer directly, and workshops for family members and friends who are struggling to be supportive and understanding. Since 2001, with the exception of one time because our son was getting married, my husband and I, along with our daughter, have attended the conference annually and are still amazed at how much we continue to learn.

The OC Foundation is beginning its first national public awareness campaign-another major step forward towards public awareness, understanding, and support. Hopefully, the silence caused by the stigma of OCD will give way to openness and empathy.

I have written about what the OC Foundation does for all people. What has it done personally for me and my family? It definitely has changed our lives for the better! We have become well-informed from all the conferences and newsletters. These things give us the understanding and strength to move forward with more hope, confidence, and knowledge. All the conferences have given us the opportunity to question, to socialize, and to realize we are

not alone and isolated in this struggle. At the very first conference we attended, we were surprised to meet another family from our community. We have become very good friends and a major support for each other. At the conferences, we have always found the doctors/therapists to be approachable, willing to answer questions, address concerns, and provide information. At our first conference, we met Dr. Michael Jenike. We expected to be somewhat intimidated since he is a prominent doctor. Not so! We found him to be a deeply caring human being!! We were inspired enough to make an appointment for a consult with him at Mass General. With his support and encouragement, and his ability to put a smile on our faces even when we were in emotional pain, our daughter became a patient at the OCD Institute at McLean Hospital, a major positive turning point in her struggle with her illness.

How is our daughter today? She lives on her own in the Boston area, a choice that she made so that she could continue intensive therapy as an outpatient with two wonderful members of her treatment team from the OCD Institute. Dr. Jenike continues to be her psychiatrist and our guardian angel! Our daughter works as a volunteer at a law firm that specializes in mental health advocacy, a position that she is passionate about. She is studying for, and preparing to take the LSATs, and is determined to become a mental health advocacy attorney. She has joined a gym and is taking exercise and yoga classes. Her self-esteem has returned and she is back socializing, hanging out with other professionals when, in the past, so ashamed of her "doing nothing," she kept her distance. She has developed a deep interest in politics, and is an unbelievably informed debater. I always lose!

Does she have some bad days? Yes! But she has started to master the techniques that bring her symptoms under control, and she is no longer letting the symptoms run and ruin her life. She is taking charge and becoming a determined fighter. In place of dark clouds, we are beginning to see rays of sunshine!!

The return to a happy, productive, fulfilling life that I wish for our daughter, I wish for all sufferers. Thank you Patti, Jeannette, Daisy, Joy, and all who serve the OC Foundation, for all that you do on behalf of so many people affected by this horrible illness. A heartfelt thank-you to all the professionals who have devoted their lives to the care and treatment of so many whose lives have been impacted by this illness. To all of you, thank you for being the anchor that holds us and keeps us strong, and for helping us to keep the faith that one day, with the aid of research, the fight will be over. We WILL DEFEAT OCD AND THE OC SPECTRUM DISORDERS!!!

Update on BDD

(continued from page 7)

information for both clinicians and BDD sufferers alike, including self-assessment tools to help readers better understand BDD and help them to determine if professional psychiatric treatment is necessary; step-by-step instructions on how to overcome your BDD-related symptoms; information for friends and family members who believe a loved one may be suffering from BDD and much more.

In addition, Dr. Katharine Phillips, Director of the Butler Hospital Body Image Program in Providence, R.I., has recently updated and expanded her renown and exceptionally informative book entitled *The Broken Mirror: Understanding and Treating Body Dysmorphic Disorder*. This newly revised edition offers the latest and most accurate information and recommendations about effective treatments for BDD. In addition, it provides helpful advice for loved ones and friends on how to cope with the disorder. Written for professionals, BDD individuals, and their families and friends, this newly updated version is a demonstration of the vast accomplishments that have been made in recent years toward developing a better understanding of BDD.

Many of the treatments and self-help guidelines offered in these books are ones provided by Dr. Wilhelm and her colleagues at the Massachusetts General Hospital/Harvard Medical School Body Dysmorphic Disorder Clinic & Research Unit. Founded and directed by Dr. Wilhelm, the MGH BDD Clinic has become internationally known for its cutting edge research and state-of-the-art patient care. The BDD Clinic is one of only a few clinics in the United States, and the only clinic in Boston, specializing in the care and treatment of individuals suffering from BDD and related disorders. Treatments offered include CBT and medication. The program also offers consultations, evaluations, and follow-up care.

In addition to clinical care, the MGH BDD Clinic consists of a research unit where breakthrough research is being conducted. The Research Unit currently focuses on studies concerning information processing, perception and interpretation, neuropsychology, neuroimaging, psychophysiology, prevalence, and treatment of BDD. In addition to active clinical

and research services, the Clinic serves an educational purpose, with research fellows and graduate students actively involved in patient care and research.

The Butler Hospital and Brown Medical School Body Image Program, directed by Dr. Phillips, is another of only a small number of clinics specializing in the care and research of BDD. At the Body Image Program, Dr. Phillips and colleagues are devoted to conducting research to further our understanding of BDD and to developing the newest and most effective treatments for BDD.

BDD is an illness for which there is a lack of knowledge and awareness among healthcare professionals, as well as the general public, meager funding for research, and poor access to treatment. Hopefully the work that is being done now will lead to more effective diagnosis and treatment.

For more information about BDD, contact the Neysa Jane BDD Fund
679 92nd Avenue North
Naples, FL 34108
neysabdd@comcast.net
(239) 594-5421

"OCD IN THE CLASSROOM" IS AVAILABLE AGAIN

"OCD in the Classroom" is available again from the OCF Foundation. "OCD in the Classroom" is a multimedia program designed to "educate educators" about the effects of OCD on a child's performance in the classroom. The program kit contains two videos: "Jake's Story and the Kids' Panel" and "How to Recognize and Respond to OCD in School Age Children." It also includes a "Presenter's Manual" that contains a tightly written script that outlines a complete presentation that can be given by a parent or a mental health professional. The presentation describes the causes and treatments of OCD and contains information on the effects that OCD has upon a child's ability to study and learn. The kit also contains transparencies.

There are also two pamphlets in the set: "School Personnel: A Critical Link in the Identification, Assessment and Treatment of OCD in Children and Adolescents" by Gail Adams, Ed.D. "Obsessive Compulsive Disorder in Children & Adolescents" by Dr. Hugh F. Johnston and J. Jay Fruehling, M.A. "OCD in the Classroom" is available from the OCF for \$45.50 for members of the OCF and \$50.50 for non-members. These prices include shipping and handling. To order, call Leslie at 203-401-2070, Ext. 14 or e-mail her at capezzone@ocfoundation.org.

Focus on Giving: Using A Charitable Remainder Trust to Make A Gift to A Non-Profit

by Kathleen Bornhorst, Esq.
Pepe & Hazard
Hartford, CT

Charitable Remainder Trusts are trusts that provide fixed or variable payments to individuals for a period of years or for their lives. When the specified period ends, the property remaining in the trust is paid to a charity. A charitable deduction at the creation of the trust is allowed, based on the current value of the charity's right to receive the property at the end of the trust term. Thus, Charitable Remainder Trusts can be ideal vehicles to provide tax benefits to the donor, create an income stream for the donor or in a special needs trust for a child and ultimately benefit a charity such as the OC Foundation.

Charitable Remainder Trusts allow the taxpayer to convert highly appreciated assets without erosion by capital gains tax. Because a charitable remainder trust is tax exempt, the taxpayer will have the full value of the asset working for her to produce income. For example, taxpayer transfers \$500,000 of IBM stock with a basis of \$100,000 to a charitable remainder trust. The Trustee sells the IBM shares and pays no capital gains tax. The full \$500,000 (as opposed to \$420,000 if the taxpayer had sold the shares and paid the tax) is invested and grows on a tax free basis until distributions are made to the taxpayer or her beneficiary. In addition, the taxpayer will have a current charitable deduction of \$150,000± depending upon the terms of the trust.

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 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 payment remains 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, 2006, husband and wife place \$500,000 in a charitable remainder trust which provides that 5% of the initial value of the trust (i.e., \$25,000) will be paid to the taxpayers annually during their lifetime. Following their deaths, the property will be distributed to a qualified charitable organization. The taxpayers will receive \$25,000 each year. If when both husband and wife die in 2012, the trust has grown to \$535,000, that amount will be paid to the charitable organization selected by the taxpay-

ers. Because the taxpayers have an income stream, they will have a \$249,075 charitable deduction in 2006 even though the charity will receive nothing until their deaths.

Charitable Remainder Unitrusts

The taxpayer places property (cash, stock, land, etc.) into the charitable remainder trust and receives 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, 2006, husband and wife place \$500,000 in a charitable remainder trust, which provides that 5% of the annual value of the trust will be paid to them in annual installments during their lifetimes. Following their deaths, the property will be distributed to a qualified charitable organization. The taxpayers receive \$25,000 in 2006. If, on January 1, 2007, trust assets are worth \$503,891, the taxpayers will receive a total of \$25,191 during 2007. After that, payments will increase or decrease depending on the value of the trust. If after the death of husband and wife in 2012 the trust has grown to \$519,760, that amount will be paid to the charitable organization.

Advantages of One Form over the Other

With a Charitable Remainder Annuity Trust, 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).

With a Charitable Remainder Unitrust, if the trust grows in value, the taxpayer benefits from the growth and her annual payment is better able to keep up with inflation. In contrast to a Charitable Remainder Annuity Trust, the taxpayer can add property to a unitrust. If she wishes to spread out her contributions to the trust (e.g., \$50,000 this year, \$50,000 next year, etc.), her use of a unitrust would require no new instrument. A unitrust has more planning flexibility. For example, it 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).

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 in the first 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.

Special Needs Charitable Remainder Trusts

A charitable remainder trust can be an ideal vehicle for a Special Needs Trust. For example, mother, age 70, can place \$500,000 into a Charitable Remainder Trust retaining a 5% annuity for her life and following her death, for her son, currently age 43. Following son's death, any remaining assets will be paid to a charity such as the OC Foundation. Mother will receive \$25,000 annually until her death. Thereafter, \$25,000 annually will be held in a Special Needs Trust for son [for more on Special Needs Trusts, see the Winter 2006 edition of this Newsletter]. Following son's death, any remaining assets will be distributed to charity. Mother will receive an income tax charitable deduction of \$122,000 in 2006.

Bulletin Board

(continued from page 2)

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 DISORDER?

Do you still have symptoms?

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.

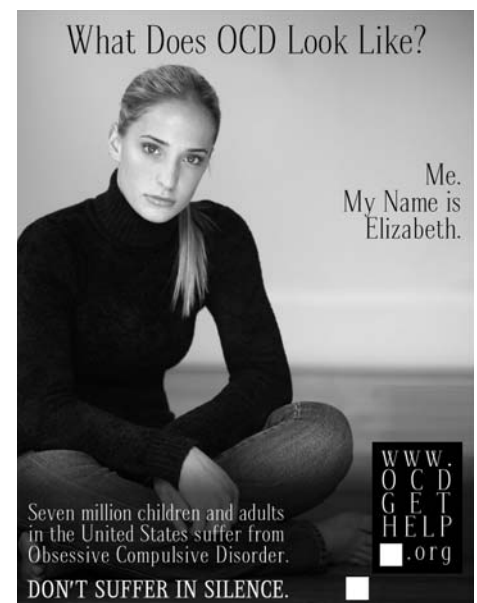
How to Join this Research? Call us at 443-287-2292 or e-mail Marco Grados at MJGrados@jhmi.edu and let us know if you are interested in participating and when we can reach you.

Your participation will help us understand family functioning in children and adolescents with OCD.

Principal Investigator: Marco Grados
M.D., M.P.H.

(continued on page 18)

WATCH FOR OUR PSA



What Does OCD Look Like?

Me.
My Name is
Elizabeth.

Seven million children and adults in the United States suffer from Obsessive Compulsive Disorder.

WWW.OCDGETHELP.org

DON'T SUFFER IN SILENCE.

Bulletin Board

(continued from page 17)

OCD KIDS – A MONTHLY SELF-HELP GROUP FOR PARENTS OF CHILDREN WITH OCD

Meeting every third Monday at 7:00 pm in the Outpatient Pediatric Psychiatry Department of Akron Children’s Hospital at 300 Locust Street, Suite 280 in the Conference room.

- Informative
- Supportive
- Confidential

Contact info

email: oocccdddkids@yahoo.com, or phone: Susan @ 330.499.0373, or on the Web: www.ocfoundation.org phone: 203.401.2070

Ask about the Akron Ohio Support Group!

AKRON/CANTON AREA OCD/SCRUPULOSITY SUPPORT GROUP

Meetings 2nd and 4th Tuesday evenings (2nd only in Dec.)

7:00 pm - 8:30 pm at Queen of Heaven Parish (in the Bride’s Room)
1800 Steese Road in the City of Green

For information, contact Susan at 330-499-0373 or email at: Ocsrupsupport@aol.com

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.



The OCD Foundation of Michigan* Announces

CAMP REDWING

A weekend camping experience for Kids with OCD

Ages 7-15

August 4-6, 2006

At

The Howell Conference and Nature Center

Howell, Michigan

For more information and a reservation form, contact:

OCDmich@aol.com

Or call (313) 438-3293

* This group is not an affiliate of the OCF.

“What Does OCD Look Like?”

(continued from page 1)

don’t have to be ashamed, and we don’t have to suffer in silence,” says McIngvale who was diagnosed with OCD at the age of 13.



McIngvales’ OCD was so severe that it was believed at one time to be untreatable. Contamination issues made her a prisoner to washing her hands 75-100 times a day. Her compulsions meant locking the door 42 times, sitting up and down in her chair 42 times, and washing her hair 42 times, before she could move on to her next activity. Eventually, she was hospitalized and treated at the Menninger Clinic.

McIngvale was interviewed on April 4th on “Good Morning America.” She talked about her OCD and how she beat it in a series of media appearances in the next several months.

In coordination with the Foundation’s National Public Awareness Campaign, the OCF’s web site was updated and redesigned. Log on and take a look at it and tell us what you think. www.ocfoundation.org

Compliance with Solicitation Regulations

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

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

CALLING FROM OUTSIDE FLORIDA. OCF's registration number in Florida is CH8507. Maryland: A copy of the documents and information submitted by the OCF pursuant to the Maryland Charitable Solicitations Act are available for the cost of copies and postage from the Secretary of State, State House, Annapolis, MD 21401, Telephone (401) 974-5534. OCF's registration number in Maryland is 5015. Mississippi: The official registration and financial information of OCF may be obtained from the Mississippi Secretary of State's office by calling (888) 236-6167. OCF's registration number in Mississippi is C1143. New Jersey: INFORMATION FILED WITH THE ATTORNEY GENERAL CONCERNING THIS CHARITABLE SOLICITATION MAY BE OBTAINED FROM THE ATTORNEY GENERAL OF THE STATE OF NEW JERSEY BY CALLING (973) 504-6215. OCF's registration number in New Jersey is CH1461800. New York: A copy of the most recent annual report filed by OCF with the New York Secretary of State may be obtained by writing to Charities Bureau, 120 Broadway, New York, NY 10271, Telephone (518) 486-9797. OCF's registration number in New York is 66211. North Carolina: A COPY OF THE LICENSE TO SOLICIT CHARITABLE CONTRIBUTIONS AS A CHARITABLE ORGANIZATION OR SPONSOR AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE DEPARTMENT OF HUMAN RESOURCES, SOLICITATION LICENSING BRANCH,

BY CALLING (919) 733-4510. OCF's registration number in North Carolina is SL002059. Pennsylvania: A copy of the official registration and financial information may be obtained from the Pennsylvania Department of State by calling toll free, within Pennsylvania, (800) 732-0999. OCF's registration number in Pennsylvania is 15687. Virginia: A copy of the OCF's most recent financial statement is available upon request from the State Division of Consumer Affairs in the Department of Agriculture and Consumer Services. Washington: Additional financial disclosure information may be obtained by contacting the Secretary of State toll free, within Washington, at (800) 332-GIVE. OCF's registration number in Washington is 6363. West Virginia: West Virginia residents may obtain a summary of the registration and financial documents from the Secretary of State, State Capitol, Charleston, West Virginia 25305. REGISTRATION WITH A STATE AGENCY DOES NOT CONSTITUTE OR IMPLY ENDORSEMENT, APPROVAL OR RECOMMENDATION BY THAT STATE. THE OCF DOES NOT HAVE A PROFESSIONAL SOLICITOR. ONE HUNDRED PERCENT OF EVERY CONTRIBUTION IS RECEIVED BY THE OCF. DONATIONS WILL BE USED TO UNDERWRITE THE OCF'S PROGRAMS, ACTIVITIES AND OPERATIONS AS WELL AS FOR RESEARCH.

To Continue, we need YOU

Name _____

Address _____ City _____

State _____ Zip _____ Telephone (_____) _____ E-mail Address _____

Please renew my membership in the OC Foundation

I wish to become a member of the OC Foundation

\$45 Regular Member (Canadian US \$50, Overseas US \$55)

\$65 Family Membership (Canadian US \$70, Overseas US \$75)

\$85 Professional Member (Canadian US \$90, Overseas US \$95)

Additional Donation \$ _____

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

Please check your type of credit card: VISA MASTERCARD AMERICAN EXPRESS DISCOVER

Credit Card # _____ Expiration date _____

Amount \$ _____ Signature _____ Date _____

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

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

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

ADDITIONAL DONATIONS TO SUPPORT OCF'S WORK ARE GRATEFULLY ACCEPTED

You may photocopy this form to keep your Newsletter intact.

www.ocfoundation.org

Time-Sensitive Material — DO NOT DELAY!

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Permit No. 337

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