International OCD Foundation

OCD Newsletter

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FROM THE FOUNDATION

Nearly 900 Attendees Make the International OCD Foundation's 2009 Conference an Enormous Success

Terry Murphy, Michael Jenike, MD, and OCDF President Diane Davey at the OCDF's 16th Annual Conference

It took fifteen years for our Annual Conference to return to Minneapolis, the site of our first conference in 1993, but it was worth the wait. From August 7-9, a total of 894 attendees, the majority of whom had never attended an International OCD Foundation Conference before, descended on the Twin Cities for more than 100 sessions and a dozen support groups.

The feedback we received was incredibly positive, with 94% of attendees listing their experiences as either "Very Good" or "Excellent." A large reason for this was the high quality of our speakers and sessions, which many attendees listed as their favorite parts of the Annual Conference.

Our presentations included several experiential sessions that allowed attendees to learn through hands-on activities. Drs. Gail Steketee and Randy Frost held a session on hoarding in which they encouraged participants to actually de-hoard during the workshop. Dr. Barbara Van Noppen, Dr. Michele Pato, and Constantina Boudouvas worked with families of individuals with OCD to create behavioral contracts with their loved ones, and an OCD Fashion Show conducted by Drs. Jason Spielman, Marilyn Cugnetto, and E. Katia Moritz had the children in attendance walking on a runway and singing karaoke.

In addition to these experiential sessions, other highlights included motivating personal stories from Randy Herrera, Jeff Bell, and Elizabeth McIngvale's family, our always well-received session on medication by Dr. Michael Jenike, and the annual Virtual Camping Trip led by Dr. Jonathan Grayson.

During the keynote address, the Foundation was also honored to provide Dr. Michael Jenike with the Patricia Perkins Lifetime Achievement Award for his pioneering work in OCD research and treatment. Following the award presentation, Dr. Jenike and Terry Murphy, author of *Life in Rewind*, gave a poignant presentation called "Finding Hope and Optimism Every Day." The presentation concluded with a moving video tribute to several people who have overcome great odds in their battles with OCD.

If you were not able to attend this year's Conference, you will still be able to get a small taste of what you missed. In our upcoming Winter newsletter, we will feature articles from a few of our most popular speakers.

Once again, to all of those who attended, provided your insight as a speaker, donated your time as a volunteer, or otherwise contributed to a very successful Conference – thank you! We hope you'll join us and the rest of the OCD community at our 17th Annual Conference at the Hyatt Regency Crystal City, just outside of Washington, D.C., from July 15-18, 2010!

IN THIS ISSUE

FROM THE FOUNDATION

OCD Awareness Week

By Jeff Bell

Jeff Bell is a National Spokesperson for the International OCD Foundation and author of the newly-published book, "When in Doubt, Make Belief: An OCD-Inspired Approach to Living with Uncertainty." He can be reached by email at ***jeff@BeyondTheDoubt.org****.*

What is OCD? How common is it? Does treatment work? Is my husband's perfectly arranged sock drawer evidence that he has a problem? Are people with OCD really as quirky as that guy on TV, Detective Monk?

These are just a few of the many recurring questions I get in my travels on behalf of the International OCD Foundation, and I'm guessing that you, too, find yourself fielding similar questions from friends, relatives, and colleagues. I'm encouraged by the current level of interest in OCD—perhaps you've noticed the recent media and pop culture fixation with the disorder!—but I'm also coming to realize just how little the average American knows about obsessions, compulsions, cognitive behavior therapy, and the like.

The good news is that for seven days in October, we—all of us in our OCD community—have an unprecedented opportunity to raise awareness about OCD, the challenges it presents, and the hope that treatment offers. Together, we can join our voices and pool our resources, coming together in ways that we never have before. We can do all this simply by playing a role, large or small, in the OCDF's inaugural OCD Awareness Week, October 12th through 18th.

Over the past several months, OCDF staff and volunteers across the country have been coordinating a wide variety of Awareness Week activities aimed at educating audiences about OCD. Our affiliates have arranged community talks; our publicity team has set up local and national radio, TV, and print interviews; and our online crew has put together a special section of our web site, offering numerous ways for members to help spread the word via email and social networking sites.

All that's missing now is you.

On behalf of the OCDF, I'd like to invite you to make this project your own. Its success truly depends on your involvement, and getting involved couldn't be easier. Simply log on to our website (**www.ocfoundation.org**) and spend a few minutes looking over the OCD Awareness Week section. There you will find step-by-step instructions on how you can lend your support—whether by attending a local affiliate's awareness talk, by adding your voice to public discussions (from talk shows, to editorials, to online forums), or perhaps just by directing your friends and family to the OCDF's online resource center and/or Facebook page. If you have any questions, please feel free to email me at **jeff@BeyondTheDoubt.org** and I'll be glad to point you in the right direction.

One of the most frequent questions I get from OCDF members is, "How can I best be of service to our community?" I'm afraid I don't always have specific suggestions; but at this particular juncture, the answer is clear: join us in making OCD Awareness Week an annual event with the power to change lives!

OCD NEWSLETTER

The OCD Newsletter is published by the International OCD Foundation, Inc.

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The International OCD Foundation (OCDF) is a not-for-profit organization whose mission is to educate the public and professionals about OCD in order to raise awareness and improve the quality of treatment provided; support research into the causes of, and effective treatments for, OCD and related disorders; improve access to resources for those with OCD and their families; and advocate and lobby for the OCD community.

Message from the President

Dear Friends,

For those of you who were able to attend our 16th Annual Conference in Minneapolis, I hope you were as impressed as I was with the quality of the programming and the wonderful community spirit that always accompanies our conferences. I was so pleased to meet so many wonderful new people this year and to reconnect with old friends and colleagues. For those of you who were not able to attend, I hope you will take a look at the thorough review article on the front page of this newsletter, and I hope you will all plan to attend next year's conference in Washington, D.C.

OCDF Board members at the 16th Annual Conference. Back row: Michael Stack, Denise Egan Stack, Diane Davey, Jan Emmerman, and T. Carter Waddell. Front row: Michael Jenike, Joy Kant, Jeff Bell, Chris Vertullo, and Tom Lamberti.

An exciting announcement that was made at this year's Conference is that the Foundation has officially changed its name to the International OCD Foundation. The Board of Directors voted on the name change earlier this year because we wanted to underscore the work the Foundation is doing – not just in the United States, but all over the world – to educate and assist people with OCD and their loved ones. We have also long believed that not having the full, official name of the disorder that we represent in our title was somewhat confusing, and that this will help to clarify things. Of course, this does not change the fact that we also represent people with OC Spectrum Disorders, nor does it change any of the work that we continue to do. It only helps to broaden and more clearly define our mission as we move forward! You will begin to see this new name reflected in our printed materials and on our website, along with a new logo that we hope to be able to unveil soon.

Denise Egan Stack, LMHC, and Diane Davey, OCDF Conference Co-Chairs

I also want to announce that we have designated the week of October 12th-18th as OCD Awareness Week. This is an idea that we have long had, and we are so excited to be getting it off the ground this year! Please read Jeff Bell's article in this newsletter about how you can get involved in this exciting new yearly event. It will take everyone getting on board to make this as successful as possible, so please let us know if you are willing to help out in your community. Our local affiliates will be sponsoring local events to coincide with this week, so you can also check their websites for more information about events that may be happening in your area.

As our leaders in Washington continue to debate health care legislation that will hopefully result in better and more comprehensive coverage for all people, including those struggling with OCD, I am reminded that organizations like ours serve a vital role in our individual communities, our country, and beyond. Our membership is larger than ever, which only speaks to the number of people who are in need of the services that we provide. There are even more who suffer in silence, and we need to reach them as well. As we enter the season of giving thanks and giving back, I hope you will remember the OCDF in your plans for annual charitable donations. We need your help to be able to achieve all of the parts of our mission. It is not beyond our grasp or our imagination; we simply need the commitment of our community to get it done. We can and we will!

Diane Davey
President,
International OCD Foundation Board of Directors

Correction: In the Summer 2009 issue of the OCD Newsletter, the headings of the two columns that appear on p13 were switched – the column on the left should be 'Obsessive Compulsive Disorder' and the column on the right should be 'Eating Disorders.'

FROM THE FRONT LINES

Bitten By a Squirrel

By Cami Ann Hofstadter

It was love at first sight. There I was, at a friend's party, a divorced baby-boomer with a career in higher education, and I wasn't supposed to act like a teenager. But when Andy stepped over the threshold I was lost. He had the deepest blue eyes I'd ever seen and a stunning full head of grey hair, and his whole demeanor was that of a very sweet and kind man. When he said, in a voice so soft that I had to lean in to hear, "I want to wish you a Happy New Year," my fate was sealed.

For the next seven years we shared our lives, until a terminal illness robbed me of my illusions that an OCDer like Andy could actually go through a wedding that he planned with perfect consistency. It wasn't until after his death, when I was whining in yet another session with a therapist specializing in issues of death and dying that I came to see how fortunate I was to have experienced Andy's love, OCD and all.

Like a lot of people dealing with the effects of what is often called the Shame-Based Disease – OCD – we kept it a secret. When he succumbed to a brief terminal illness and the truth slowly trickled out, friends and family would invariably ask, "How could you ever love a man like *that*?" But OCDers are lovable too and, while sometimes challenging, his mental disorder filled our life with laughter, excitement and surprise. Then, when strangers like the mailman and pharmacist lamented the death of "such a wonderful man" or volunteered little stories about his kindness and sense of humor, I could honestly say, "Yes, I was very fortunate to have loved him for so long."

Almost sixty years old when we met, he could probably have been labeled a *hoarder*, *orderer* and *checker* since his childhood, although it wasn't until four years into our relationship that he received an official diagnosis of OCD. From his own stories he was always considered different or, as he said, "I got side-tracked a lot," and he was changed from one school to another to improve his self-discipline. His little-boy mien remained throughout his life and it was particularly obvious when he froze at a construction site to watch workers maneuver their trucks, or when he shot a whole 36-exposure roll of film of concrete being poured into another. During those moments, as well as when he was wrapped up in one of his many sorting rituals, he'd stick his tongue out of the side of his mouth and nothing could disturb him. It was exactly this combination of child-like fascination over life and the accompanying concentration on the tasks he enjoyed that made my maternal love spring to the surface.

If I had to sift through Andy's OCD symptoms to categorize them only in a broad sense, I'd settle on *things* and *rituals*. But life can't be that neatly distilled and, in his case, *kleptomania* and *paranoia* were among the other manifestations of his mental disorder that challenged my inherently positive nature while leading me to my suppressed sense of the comical.

Hotels came with their own checking rituals – exactly three times for the drawers and twice under the bed – but they also made me feel special because of his concern for comfort. Since this was before 9/11, he boarded all flights with a heavy carry-on of all possible tools and equipment that he was compelled to use immediately upon checking in. Regardless of the standard of the hotel – some properties were five stars – he had to exchange the showerhead for one of his own and then all light bulbs had to be checked. Nothing could stop him; the routine simply had to be completed. The lengthy process often led to other must-do activities, such as disconnecting a noisy ceiling fan or making a long list of supplies that he felt he had to replenish. "Being prepared" was one of his mantras but I loved the way I felt safe and secure and cared for when we travelled.

Andy's kleptomania and paranoia were particularly difficult to deal with but they were also dependable sources for laughter and light-hearted banter. Like in scenes of the *Three Stooges* we'd bump into each other as he secretly tried to pack towels, ash-trays and other smaller items from a hotel while I'd chase after him. Until his dying days he also remained convinced that "someone" regularly had stolen one book or one magazine from his enormous collections of both, or that one piece of clothing was missing from his locked closets, to which only he had the keys.

When he was engulfed by one preposterous incident after another I learned to laugh out loud over the funny absurdities in his behavior. If it wasn't pants "missing" it was a piece of hidden fruit from the refrigerator, or a broken vacuum from the hallway closet, or 5 cents that he absolutely *knew* he'd left in a dish. I turned these events into a comic routine that amused us both; since his death, this newly-found sense of humor has served me well and, happily so, in life without OCD.

Through his paranoia I also learned to anticipate problems and, even now, preparing for some eventuality remains a good tool for someone no longer as agile or as adjustable as a teen. For instance, his obsession with flash-lights and extra batteries ("You never know when there's going to be a fire in the hotel") only makes sense. And his inability to rid himself of old jars and containers would make any recycler squeal with joy.

Time is a constant enemy to OCDers and although – or maybe, *because* – Andy never learned to manage it, time-pieces of all kinds crowded his home and his compulsion to buy more never ended. He owned more than twenty wrist-watches, and clocks were one of his favorite gifts to give. Each time when daylight savings time started he'd spend hours re-setting all of them, pleased with himself over something he could "control." I started looking at the clocks like they were his toys and seeing him have his own "playtime" with them made me happy.

Although he was obsessive about what he called "being in charge" I loved it when I was the beneficiary of his concern with my physical welfare. He never went to a restaurant or a movie without a sweater and always reminded me, quite father-like actually, that I too should take one. If – for some reason – I forgot one, there was always the large trunk of his car. Loaded with maps, flashlights, ropes, local phone books, pens and paper, raingear and hats, all neatly packed into plastic snap-lock containers, it also contained two extra sweaters meticulously folded into their own special cloth bag.

One time I mentioned how scared I was about being stuck in the elevator during one of our frequent power-outings in South Florida and the next thing I knew he attached a small flash-light to my key-chain. After his death I counted more than fifty of them, along with two-hundred batteries, in one of his locked closets. If I live to be one hundred I'll never have to worry about being in the dark again!

Although his obsession with impeccable grooming – a ritual that took him two hours every morning and at least one hour in the evening – often made us late for events, my olfactory nerves adored him. When he sat down at the breakfast table, surrounded by a constant scent of baby powder and soap, I indulged in the maternal feelings I hadn't enjoyed since my own two sons had left the nest.

Part of loving somebody is the legacy that they leave you, and with Andy it was his OCD-induced amassment of things. During the lengthy clean-up process after his death – opening containers of things inside containers of more things, and so on, almost *ad infinitum* – I separated those heaps that I could use from those going to charity. Now, in my ninth year after his death, I still haven't had to buy new toothbrushes, baking foil or stretch wrap, dental floss or soap, pens or paper pads. As I continue using them up they still make me laugh and they still make me feel cared for. They are all part of what made Andy lovable, OCD and all.

FROM THE FRONT LINES

Going to War with OCD

By Lisa Buchanan

Lisa Buchanan runs a support group for parents of children with OCD in Plano, Texas. If you would like more information about how to start your own parents' support group in your area or if you live in the Plano area and would like to attend her group, please contact her at **ocdparenthelp@yahoo.com**.

I had just said "Goodnight" to my three kids and crawled into bed after a long day. I was lying there talking about what our next day looked like with my husband, kissed him goodnight, and started to drift off to sleep when my 13 year-old son Conner burst through the door in tears.

"Mom – it's OCD."

Like a scene from an old war movie, the U-Boat battle warning sounds were going off – "Whoop, Whoop, Whoop. Man all stations!" I had just kissed him goodnight not fifteen minutes before this and he had seemed fine. What had happened? We had been talking about our trip to Six Flags the next day and he had been trying to decide if he wanted to go.

Any mother without OCD in her life would ask, "What does Six Flags have to do with OCD? How could that possibly get a kid into a panic?" This is the nature of the OCD beast. It can come on suddenly and, most of the time, it just doesn't make sense – sometimes not even to the person with OCD.

Luckily, my son and I have gotten so good at using the tools we've learned from his therapist that we know exactly what to do – we do it quickly and we do it very well, like trained soldiers. This particular night was an example of habituation and how it works in our OCD therapy. The first thing I did was ask him, "Give me the loop." What this means – in our "Special Ops OCD Code Language" – is that I'm asking him to tell me what is looping in his OCD brain, or what is the thing, phrase, or thought that is causing the panic and anxiety (the OCD episode). He usually says at first, "I don't know." This is because when OCD is taking over someone's brain it can be so confusing with the whirlwind of things going on that it is hard to identify the cause of the panic. I've learned to coach him by telling him to focus and give me "the sentence." A trained therapist is much better at this than I am as far as figuring out the "loop." I can only guess, so I've put some of the responsibility on my son. I want him to be able to do this exercise himself one day, so he needs to be the one to "search and destroy." My other goal is to get this thought gone ASAP! We do not like to make OCD welcome in our house, so being swift and deadly is the OCD battle plan.

On this particular night, after his initial response of "I don't know," I said, "Give me the sentence. Tell me what I need to be saying." I could hear him calming himself and then he said, "Someone's going to die." In a household without OCD this might sound crazy and disturbing, but in our house it's like one tiny move closer to the goal, to the enemy we want to overtake. I then asked him, "At Six Flags?" He responded with a quick, "Yes" – we are really covering ground now! We're almost on the target! My last question was, "Is that the thought?" Now, his answer would only come with practice since we have found that if we get the wrong sentence, this exercise doesn't really work. It helps a little but for it to be the deadliest in getting rid of OCD – which is the total objective – you have to really zero in on the correct thought. Conner's response was, "No – tomorrow." I asked, "Someone's going to die at Six Flags…tomorrow?" "Yes."

Right now I am the tape recorder that helps him with habituation, but eventually I want him to do this exercise totally on his own. He has to hear it – not think it – for it to be effective, so he'll need a small tape recorder or a friend to be able to do this without me or his family. (I'm thinking about his life as a young adult where Mom might not always be there.) Also, children tend to habituate faster so if you're an adult with OCD, don't be discouraged if it takes longer. It still works. Every brain will habituate. For a lingering OCD thought we do use a tape recorder and incorporate this into any OCD homework that might need to be done, but in the heat of battle or if we're someplace without the tape recorder my voice is a good stand-in.

I then ask him, "What's your number?" (When he was younger I would ask, "Where are you on the Feelings Thermometer?" – taken from Dr. Aureen P. Wagner's book, Up and Down the Worry Hill). He tells me, "7." I then start the "loop sentence" – *Someone's going to die at Six Flags tomorrow. Someone's going to die at Six Flags tomorrow. Someone's going to die at Six Flags tomorrow.* After about a minute or so I ask again – "What's your number?" "5." We can almost taste victory. The words go on and on – my husband takes over for a bit repeating the phrase and within a relatively small amount of time, Conner is at a zero. Sweet victory!!! I pat him on the back, give him a hug and tell him, "You are the ultimate OCD Warrior!" He smiles and goes back to bed. The taste of victory over OCD is sweet – for the both of us.

The next day, I happily kissed Conner and waved good-bye as he, my husband and daughter drove off to go to Six Flags. Conner was also victorious over another OCD culprit – avoidance!

Join us at the International OCD Foundation's 17th Annual Conference in Washington, D.C

The Hyatt Regency Crystal City is perfectly situated to allow you to access the entire D.C. area. Visit monuments and museums, take in a show or a game, or tour historical sites, all just minutes away.

July 15th-18th, 2010
Hyatt Regency Crystal City,
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Please check **www.ocfoundation.org** later this Fall for more registration details! This training is limited to the first 30 registrants.

ORGANIZED CHAOS: FOR TEENS & YOUNG ADULTS

Monster

By Anna Hibschman

When I was little, I had a monster in my closet. He was shrouded, scary, and mean. Not only that, but he had it out for me. I only knew that the monster lived there, in the darkness, waiting for me to fall asleep before he would come out and play, spinning bad dreams for me to witness. To me, he was real. I eventually outgrew him, only to befriend an even scarier creature.

Fast forward to my sophomore year of high school. It was Chemistry class, my second to last class of the day. My best friend Liz sat to my right. We wore uniforms, it being a Catholic school, and as most teenage girls would we rolled up our skirts past our knees. That day started out no different then any other except, I noticed, Liz had a scab on her knee and for some reason I couldn't help but look at it.

It was strange. A scab? Why was I looking at a scab? But no, I was looking at her knee. Why was I looking at her knee? Wait! It was her legs! I was looking at her legs.

Oh. My. God.

I'm gay.

The heart wrenching panic started there, in that classroom. I justified it in every way possible. After all - it made perfect sense in my mind. At sixteen, almost seventeen, I had never had a boyfriend. I had only ever kissed one guy and I didn't even really like it. That must mean something. And guys never paid much attention to me - they must have been able to tell. I remembered one day in 4th grade when I wore a GAP hoodie to school; a boy named James Michael had the same one on and everyone made fun of him and said, "Oh look, gay and proud" – that must mean that I'm gay and proud. I was never really close to any of my girl friends, either. Wait, they aren't my girlfriends – they're just friends who are girls.

I was sure. I began to pull away, disappear in my mind. I stopped going out, inviting people over to my house, or making new friends. I was miserably content in the world I had created for myself, locked in my head. Though my friends saw this, they did nothing. Thus, I fell in love with my demon – my obsession.

A love like ours was a commitment – 24 hours a day, 7 days a week. Not only was it a committed, abusive relationship, but also it was one I held in secret and dealt with alone.

The next months drizzled by in this gray, blurred confusion. I admit I have little recollection of that time.

Then, on an overly dreary day at the start of the new year, after coming home from school, I broke. I needed help; I could think of nothing more than walking into the kitchen, picking up a knife, and ending it right there. I called my mom in tears, asking for her to set up an appointment with someone. She did so that day.

When I went to see Jasmine, a counselor, I didn't know what to say. "I can't stop thinking about whether or not I'm gay" would have worked, but I couldn't bring myself to say it – I was terrified. After all, I didn't know if she was gay or not and what if I told her and she said those three dreaded words: You are gay.

Eventually, after my romance with my obsession began to take a turn for the worse I burst. I spent only one session out of twenty talking about it. After that particular session, I pretended that I never said anything about it at all. I ended my meetings with Jasmine, embarrassed and once again beaten into submission.

During the summer before I started my junior year, because of my grandparents' illness my family and I uprooted our lives in Philadelphia, where I had been born and raised, and moved almost an hour away to the suburbs in Chalfont. I transferred schools happily, convinced that this would be a new start.

It wasn't.

I made new friends, though few. I fell in love with a boy and had my heart broken, and yet my obsession persisted. I also met my best friend May. She, like I, had transferred into school and conveniently enough she lived across the street.

However, I lived in perpetual terror. Checking, reassuring, watching, perceiving. I stopped standing

certain ways, refused to wear certain shoes, grew my hair long, and delved more into fashion My grades dropped drastically and, for once, I wasn't an honors student. I wouldn't even hold my own hand. I watched in horror as my anxiety gave me mixed messages. I learned how to hate myself.

Having the obsession became tiring. It was old news and I wanted to move forward. I had missed out on some of the greatest opportunities of my high school career because I couldn't let go of my "What if?" questions. I truly was miserable, and my poor attempt to hide it was starting to fall apart. Then summer hit.

Senior year started and I felt the need to be in control – there was going to be no more drama. Unfortunately, I was wrong. One particular day I barely made it out of class before I, quite pathetically, broke down in a bathroom stall. I couldn't take it. I begged and pleaded with God and wanted to know, "Why?"

Why was it me? I never did anything wrong. Why did I have to do this? Why was it so important? There was a part of me that knew it wasn't true, but I couldn't stop. If it wasn't the actual question of whether or not I was gay, then it was the anxiety – it was perpetual.

I was tired of checking my body to see if I would respond physically to a picture of a woman. I was tired of trying to do the "Are You Gay?" quizzes online. I was tired of trying to find information about how to tell if you're gay or not. I was tired of avoiding and tired of crying.

That day I went and poured my heart out to the school therapist. She introduced me to Acceptance and Commitment Therapy (ACT), something for which I was grateful and which helped me find the courage to ask my mom to find someone to speak with.

I started going to see Dr. Katherine, a cognitive therapist. She was the second person I ever told about my obsessions. After a few sessions, I told my mom. She didn't really react, which surprised me. I had wanted my mom to react. I needed to know – what exactly I needed to know, I couldn't tell you. I decided to tell her more – when I was obsessing sometimes I would just open my mouth and say it all to my mom. Disappointingly, she'd say something like, "I don't know what to say – talk to Dr. Katherine." Then I told my new friend May, and she was more than supportive. There would be days when, all day, I did nothing but tell May everything that flowed through my jumbled brain.

When I was working with Dr. Katherine I was terrified she would look at me and say, "You're gay." She didn't though, and we started on ACT. Then, finally, we moved to Exposure and Response Prevention (ERP) Therapy and my monster finally had a name: OCD.

The day Dr. Katherine introduced ERP to me, I thought that my heart was about to rip itself out of my chest. I was terrified and relieved.

What if I found an answer that I didn't want to hear? Even though I had always wanted one, wouldn't it just be good to know? But I didn't want to be gay! I wasn't gay! But then why was I afraid if I already knew the answer? Maybe because there was a chance that I was gay. And what's life going to be like afterwards?

My questions made me want to back out, but I was not about to let my OCD win.

Dr. Katherine and I started the process by making a list of my obsessions and worries and then rating them between 1-100. Then I started doing the exposure homework.

Now, 14 days before I start my freshman year of college, I am happy to say that I've almost made it. I might have a spike of anxiety once in a while, but it is less frequent and shorter. I can happily shop online and see pictures of the models and not feel anything. Though the road has been arduous, I'm happy to have started down it, even if I had to do it by myself with little understanding from my family.

I had a monster in my closet when I was little, and I turned on the light. I had a monster in my mind, and I kicked him out.

If you would like to submit your creative writing, personal story, or artwork relating to your OCD experience, please email your submission to **editor@ocfoundation.org**.

THE THERAPY COMMUNITY

Emotional Contamination: A Lesser Known Subtype of OCD

By Carol Hevia, Psy.D.

Carol Rockwell Hevia, Psy.D. works as a behavior therapist at the OCD Institute at McLean Hospital. She has almost twenty years of experience in treating children, adolescents and adults with OCD.

Case Study

Joe is a 25 year-old college drop-out who is currently unemployed and lives in an apartment above his parents' garage. He has a lifelong history of OCD that began at age 8 when he was plagued with symmetry obsessions and scrupulosity. Now he is struggling primarily with obsessions that he will be contaminated by a former college roommate, Connor, who was wildly successful in academics and in the business world after graduation by being ruthless and nasty and by taking advantage of those who helped him and those who "got in his way." Joe fears that if he comes into any kind of contact with his former roommate he will be at high risk of becoming like him: "ruthless, uncaring, and a cannibal of friends and foes."

During college, Joe was so terrified that he would become like his roommate that he started to avoid all friends who had contact with Connor, as well as the library where Connor studied. Joe, like Connor, was a business major and began to avoid taking any courses that would be held in the business school on campus. This became very problematic when choosing which courses to take each semester, so he switched his major to Russian Studies because that department was housed on the other side of campus. However, if Joe happened to speak to a fellow classmate who had taken a course in the business building, he needed to immediately drop not only that particular course that they shared, but also discard the clothes he was wearing at the time, his books from that class, and any current term papers in progress.

Eventually, these disruptions eroded his academic success; his grades dropped, he took a medical leave from college, and he returned home to live with his parents. Since he had shared a dorm room with Connor, he felt the need to discard all clothes, books, personal belongings, and even his computer when he moved out of the dorm. But just like the college dorm room, it was inevitable that the house would become contaminated, for even when someone mentioned Connor's name, the obsessions would be triggered and decontaminating the house became impossible due to Joe's high OCD standards and rigid rules for decontaminating. The family had an apartment built over the garage so that Joe could keep his living quarters "free from Connor's cannibalistic influence," but then he stopped even stepping into his parents' home for fear of exposure to Connor's ruthless ways. When Joe tried to take college courses online he found that the contamination seeped into his garage apartment through the computer, since Connor had an account on a social networking site online. When Joe reached the point where he was preparing to move into another apartment in a town twenty miles from his parents, and he was about to buy his fifth computer, and he no longer uttered any words with the letter "C" in it, he called a behavior therapist to get help.

Symptomatology of Emotional Contamination

Joe suffers from a subtype of OCD called Emotional Contamination. Emotional contamination is a lesser known symptom cluster of OCD in which the sufferer fears that contact with a person or place will somehow contaminate and endanger him. The worry can be that the individual with OCD is at risk to take on negative personality traits that the trigger person has, such as bossiness or nastiness, or that the sufferer will take on another's entire personality. It is fairly easy for the individual with OCD to identify the person who triggers his obsessions. Sometimes it can be a "type" of person who represents a disability that one fears contracting, such as a blind person or a person with deformed limbs. The trigger can also be a geographical location, such as a college, funeral parlor, or cemetery. Sometimes a traumatic event "marks" the physical site and is the source of the initial contamination and subsequent danger. An example of this could be the break-up of a serious relationship, a death, or a suicide attempt. Then any contact with the place where the event took place is perceived as dangerous, as if the physical contact will generate bad luck and magically endanger the person with OCD. The feared bad luck can be very specific, such as a car accident, or it can be vague, such as a general sense of impending doom.

Two hallmarks of emotional contamination are the presence of magical thinking and superstitious behaviors. Both magical thinking and superstitions are clues that the sufferer believes in a phenomenon that is inconsistent with what is generally considered true and rational in the particular society in which he lives. The person with OCD often believes that random events and coincidences never occur and that all events are meant to happen, so they therefore hold special meaning and power. Any time a coincidence occurs, the sufferer uses the coincidence as "factual evidence" that their superstitious beliefs have merit and that all others who try to dissuade them are wrong.

The exposure and subsequent obsessions are often "contained" through similar rituals to that of contamination fears. The person with OCD will avoid direct contact with the contaminated person and will clean him/herself thoroughly if he does touch the person or the person's belongings. Contamination can "magically" spread through physical contact, such as a handshake or touching a pencil that the contaminated person recently used. Often, as the OCD symptoms worsen, the contamination from another person starts to look as serious as a true radiation contamination, in that the person will actually throw out all clothes worn at the time of contact and vigorously scrub themselves down in a long shower.

The perceived danger of contamination can also be airborne so that merely sharing air space with the trigger can put the person with OCD at risk to suffer a catastrophic consequence. The sufferer may cover his mouth with a barrier to protect himself from becoming "ill" or might try to hold his/her breath when near the trigger. More often, the ritual would be an "undoing" of breathing in contaminated air by breathing out in a ritualized fashion, perhaps with a neutralizing thought that safely "deactivates" the danger of the contaminated air.

Sometimes in emotional contamination the perceived danger can spread through language and speech so that uttering a phrase or word that reminds one of the obsession can dramatically increase the perceived risk of danger. Thus the individual with OCD avoids using specific words or names and he may even attempt to control others' use of the trigger words in order to avoid escalating anxiety. The rituals can even spread to reading and writing; for example, the sufferer might avoid writing the trigger word, or if he reads the trigger name he might engage in neutralizing rituals to undo the effect of reading the dangerous word. The neutralizing rituals may be to reread the trigger phrase while having a "good" or opposite thought, or to skip reading the entire page. The person with OCD may decide to cease reading altogether in an attempt to quell his/her anxiety. As the sufferer becomes more symptomatic, the contamination can generalize further – the individual letters or punctuation symbols become dangerous as well, and the person writes words with letters left out so the reader must guess as to the exact content of the message.

Not surprisingly, exposure to the media, whether in written form, television or the internet, can become problematic for the person with OCD. News related to the triggering topic can set a sufferer into a tailspin, so the bold type titles in a newspaper or magazine are initially skimmed in an effort to stay away from triggering topics and eventually reading a newspaper is avoided altogether. Then, even touching the newspaper becomes an issue with which to contend. Particular television shows are avoided due to implied content, and the same holds true for known internet sites. However, as with other triggers and unchecked ritualistic behavior, generalization is inevitable and a further escalation of symptoms will occur if the OCD is left untreated. For example: the computer is no longer touched or used, the room that the computer is in is never entered, and the person can deteriorate towards residing in one room of their home and not venturing out due to potential danger from exposure to anything even remotely related to the contaminated person or place.

Treating Emotional Contamination

Exposures for emotional contamination will, at first, mimic germ and contamination exposures. Hand washing and showering frequencies are reduced in quantity and quality. The person touches contaminated items, uses previously avoided belongings and then cross-contaminates from "dirty" to "clean" belongings. The ERP plans start to differ when the ERP is designed to expose the sufferer to avoided words and sounds. He may write one word or phrase repeatedly and then say it out loud. The written trigger is then hung up on the person's door or walls, thus saturating both one's awake and sleeping hours with the feared stimulus. Placing the triggering written work by one's bedside is especially effective because sufferers often believe that they are more vulnerable to emotional contamination while they sleep.

(continued on p. 12)

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(Emotional Contamination, continued)

Joe started twice weekly behavior therapy outpatient sessions. He made a list of worries and triggers, both physical and mental, and rituals. Together, he and his therapist rearranged the list into a hierarchy of feared situations and triggers using a SUDS rating of 1 to 10. He agreed to cancel plans to move from his garage apartment and he kept his fifth computer. His exposures started with saying and writing Connor's name on sheets of paper and then hanging them around his computer and bed. His family learned about accommodation and not only started to block verbal reassurance but eventually, under the therapist's guidance, began to say words with C and even said the dreaded word "Connor" during ERPs. Once Joe experienced habituation to some of the initial ERPs, his sense of direction in the treatment, his hope, and his motivation dramatically increased and he was more able to take on challenging tasks since he knew that even when his anxiety was very high it would eventually drop, especially if he blocked ritualizing and retriggered himself when he slipped and ritualized. He started to drive to his old campus and progressed to sitting outside the business building. He started to socialize with other contaminated friends, use the internet again, and signed up for a business class in accounting. He eventually started to email Connor himself, which was at the top of his hierarchy. Even though they never became close friends, Joe was no longer haunted by Connor's presence in his OCD life. When he would think of Connor, and even when he thought about the dreaded personality characteristics, he would not try to push the thought away, but say to himself, "Yup, that's Connor – what a guy!" and go on with his day. Joe is now completing his third year in college and is majoring in Russian Studies with a minor in business.

Emphasizing the Need for Post-Treatment Maintenance in the Treatment of Obsessive Compulsive Disorder

By Eda Gorbis, PhD, MFCC

***Eda Gorbis, Ph.D., M.F.C.C.**, is in private practice, an Assistant Clinical Professor at the UCLA School of Medicine, Consultant for the Center for Cognitive Therapy's OCD Program in Beverly Hills, and Vice-President of OCSDA. Dr. Gorbis is also a member of the International OCD Foundation's Scientific Advisory Board.*

Obsessive Compulsive Disorder (OCD) is not as rare as previously thought. A conservative estimate is that as many as four million Americans of every sex, age, and culture experience debilitating OCD symptoms. This number grows exceedingly when considering world-wide prevalence rates. Behavioral treatment of OCD has yielded impressive results even with the most intractable of cases, including those with poor insight and "pure obsessionals." Following the extensive empirical research of Drs. Foa and Kozak, when done properly, behavioral therapy can alleviate symptoms for up to six years. This is especially true if treatment is followed with a structured relapse prevention program (Foa, 1994).

It is now well known that the nature of OCD is one of continual waxing and waning, with exacerbation under conditions of stress. However, this is equally true of many chronic medical conditions. More recently it was discovered that OCD fluctuates and exacerbates in response to hormonal conditions, imbalances, or changes (like puberty, pregnancy, menstruation, and menopause). In this short case study I would like to bring to the reader's attention the importance of attending and prevention relapse. Perseverance, consistency, persistence, and commitment: these double PCs appear to be the key to long-term, complete remission (9 to 11 years) of OCD.

Eleven years ago I treated a very complicated case. Sheila was then 28 years old and had experienced OCD since she was a teenager. As in many OCD cases, she was affected by a number of fears, each of which was further complicated by poor insight. Sheila's OCD began with contamination obsessions that exacerbated when her doctor diagnosed her with venereal disease (V.D.). This led to contamination compulsions including 3-5 hours of hand washing, repetitive body cleaning, and unwarranted returns to her doctor requesting tests for contagious conditions. This continued for a year after full recovery from her V.D.

During our initial meeting I had asked her to fill out some questionnaires about her OCD symptoms and her scores had indicated severe levels of symptomatology and beliefs in her obsessions. She feared that her loved ones would be stricken by disastrous conditions/circumstances, which caused her to worry incessantly. She also had a number of major doubting behaviors and some reassurance seeking behaviors. Doubt, the hallmark of OCD, had paralyzed her to the point that she was unable to make small decisions, leaving her life in stalemate. Following a 5 day hospitalization, Sheila responded well to three weeks of Exposure and Response Prevention therapy (ERP). At the termination of her therapy with me, her symptoms were in full remission.

It was not until 11 years later that I received a call from Sheila. She was crying and reported having a "breakdown." She was experiencing severe OCD symptoms, poor appetite, weight loss, crying spells, and depression. She also expressed suicidal ideation, without a plan or intention. I immediately scheduled an appointment with her. I knew Sheila had responded well to treatment 11 years ago and it sounded like she was eager to begin again.

During the treatment of her relapse, the content of Sheila's fears centered on the possibility that certain foods would interact with her medication and diminish their efficacy, particularly foods containing citrus. I administered the entire battery of tests including the MINI, a short form general diagnostic tool for Axis I and II disorders. I wanted to do a thorough assessment in order to start Sheila on her path to relief as soon as possible. From the onset, her obsessions did not seem to be bizarre, complicated, or especially difficult. However, within two days I realized that, without medication, progress would not be possible. This was because Sheila's insight was becoming increasingly impaired.

I referred Sheila to a doctor with whom I have worked many times in the past few years and who specializes in intractable cases. I worked with Sheila 8 hours a day, three times a week; however, not only was she non-responsive, but her symptoms worsened. She continued to experience crying spells, sleeplessness, lack of appetite, weight loss, and failed to habituate outside of session. Sheila often called me from home seeking reassurance and reporting an increase in OCD behaviors. After a month of intensive treatment Sheila was hospitalized for medication management. Because one of her medications seemed to worsen her symptoms, her prescription was changed to another OCD medication, which seemed to decrease her symptoms. Her food intake increased and she was able to sleep better.

As she did during her initial treatment, Sheila wrote diligently and was continually exposed to stimuli. Exposure consisted of drinking juices (cranberry, orange, grapefruit) with sugar pills that looked very similar to her medication, beginning with the least anxiety provoking stimuli and working towards the most anxiety provoking. During exposure, Sheila's eyes were bloodshot and filled with horror and she was extremely tearful. She was certain that the juice would dissolve her meds and diminish or destroy their efficacy.

While hospitalized she improved, but on release she worsened. Continuing to doubt and give in to her now delusional beliefs, she repeatedly sought reassurance despite my discouraging her from doing so. On the other hand, her depression was better, she had fewer crying spells, her appetite had increased, and she was sleeping better. She also reported fewer thoughts of suicide. However, an additional complication arose: Sheila had developed symptoms of Body Dysmorphic Disorder (BDD). Rather than seeing and feeling her actual size (6-8), she perceived herself as being a size 14. A part of her BDD exposure therapy involved excursions to nearby boutiques where Sheila was required to try on clothing that was clearly oversized.

Sheila was fortunate to have strong support from her family and her boyfriend, yet was progressively unhappy. One of her obsessions involved thoughts/fears that her family was far happier about her sister's engagement and upcoming marriage than they would have been about her own. These feelings brought immense guilt and shame for Sheila, since she saw herself as being a bad sister for feeling left out and envious.

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(Post-Treatment Maintenance, continued)

Today, Sheila has a 60% improvement rate, but we still have a long way to go and neither Sheila nor I have plans of giving up. I still recall that time 11 years ago when Sheila was able to accomplish 100% remission of intractable OCD. Her case provides a clear illustration of the need for vigilant post-treatment maintenance. Another case occurred early last July; following successful treatment, the client experienced 9.5 years of remission before calling to report a return of OCD symptoms. Yet another case occurred three years ago when a client who had experienced 6 years of remission returned for treatment. The relapse improvement rate for both cases was significantly (nearly 50%) lower than their rates of improvement during initial treatment.

The OCD client must not neglect him/herself. Much like a person diagnosed with a chronic medical condition such as diabetes or high blood pressure, treatment does not suddenly end once the symptoms diminish. Occasional check-ups, systemic life changes, and regular monitoring of and attending to one's condition are a must. Most importantly, the regular practice of ERP is the key to getting – and remaining – on the road to success. The importance of maintenance and relapse prevention cannot be overstated. Otherwise, old fears and their maladaptive behaviors can reappear, become reinforced, and be re-strengthened. To aid in avoiding relapse, the gains of treatment must be continually reinforced, examined, and exercised through use of repeated exposure. As Drs. Foa and Kovacs put forward, treatment eliminates fear "structures" and symptoms, but it does not eradicate the blueprints for these fear behaviors. It is these blueprints that give rise to the possibility of relapse. This is why I repeatedly remind the members of my weekly OCD group, "It is not good to feel good!" Feeling *good* is a trap that tricks you into believing that you are cured, and no longer within the treacherous grasp of OCD!

Relapse treatment of OCD is not easy, but through the double PCs (perseverance, consistency, persistence, and commitment) you can avoid the excruciating pain of not succeeding, or succeeding to a much lesser degree than that of your treatment and work your way to long-term, complete remission. In short, my theory is this:

- OCD is never to be neglected
- OCD is never cured – it is only in remission
- Short-term success is not enough
- Long-term, habitual life changes are required
- Ongoing exposure to feared stimuli is a must
- You can either have growth or excuses, but not both

Fortunately, we know a lot about OCD; unfortunately, we know far less about its causes. Yet one thing is very clear: those who accept the fact that OCD is an enduring part of their lives, rather than seeking impulsive, short-term, "feel good" behaviors or remedies, will experience the greatest success in eliminating symptoms long-term. People who suffer from OCD will have no choice but to be constantly vigilant and mindful of their ever changing, ever pervasive, and ever intrusive symptoms. Again, no cure for OCD exists, but through prolonged and repeated exposures to those events, places, people, and objects that provoke anxiety, one may gain long-term control over his or her condition.

OCDF Institutional Member Updates

We are proud to announce that many of the intensive OCD treatment programs across the country have applied to become Institutional Members of the OCDF. The OCDF's Institutional Members are all programs that offer more than traditional outpatient therapy for those who need higher levels of care. Please see the announcements below for recent program updates.

CALIFORNIA

UCLA opens new Child and Adolescent OCD Intensive Outpatient Program

The University of California-Los Angeles is pleased to announce the opening of its new intensive treatment program providing three hours of daily individual and group treatment for youth ages 8 to 17. Program features include an individualized exposure and response prevention (ERP) program, medication management, family therapy, and parent education and support. This program is in a central location (West L.A.), and out-of-town families are provided assistance with accommodations if necessary. Financial advisors are available to assist with determination of insurance coverage prior to admission. For information and appointments, please call Dr. Bennett at (310) 206-4875 or visit **http://www.semel.ucla.edu/caap/treatment.php**.

TEXAS

Houston OCD Program launches a residential program in a new beautiful location

Following the closing of the OCD Program at The Menninger Clinic, one of only three residential OCD programs in the US at the time, the treatment team made a collective decision to embrace this independence and begin a new venture. The seasoned treatment team launched a comprehensive, state-of-the-art center: the Houston OCD Program.

Nestled in the heart of the bustling Montrose neighborhood of Houston, the program resides in a beautiful 2-story home offering an inviting, warm environment. The treatment team and staff deliver expert, evidence-based treatment for clients and families who are dealing with anxiety disorders, depression and OC spectrum disorders. The program offers a continuum of services, including specialty residential treatment, intensive outpatient, diagnostic and treatment consultations, and outpatient services.

Dr. Thröstur Björgvinsson, the Program Director, commented, "While the location and structure of the program has changed, the people, our values, and our determination to offer exceptional treatment remain the same."

The program's setting fosters an atmosphere for change, while maintaining a safe environment where patients and staff work collaboratively. The cognitive-behavior therapist and patient design the treatment plan together and staff supports the patient's efforts to follow the behavior plan to maximize treatment effectiveness. The location of the clinic in a home-like setting increases the opportunity to practice exposures in realistic situations and to build confidence in maintaining treatment gains post-discharge.

Pictures of the house, located at 1401 Castle Court, Houston, Texas, can be accessed at **www.HoustonOCDProgram.org**. The Houston OCD Program will host an open house on Wednesday, October 28th from 5 to 9 PM – everyone is welcome, and light **hors d'oeuvres** and refreshments will be served. For more information about the services offered, please call (832) 298-7075 or email **info@HoustonOCDProgram.org**.

WISCONSIN

Treatment staff added at Rogers Memorial Hospital's child and adolescent programs

David Jacobi, PhD is joining Rogers Memorial Hospital in mid-September as a behavior specialist and clinical supervisor under the direction of Bradley C. Riemann, PhD. Jacobi will be working primarily with the hospital's pediatric residential patients.

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(Institutional Member Updates, continued)

Jacobi has an extensive practice background in the treatment of anxiety disorders in the US and Canada. He conducted research related to OCD as it relates to children and their families. Jacobi completed his PhD under the direction of John Calamari, PhD at Rosalind Franklin University of Medicine and Science.

Jacobi will work closely with Stephanie C. Eken, MD, a triple board-certified psychiatrist and pediatrician. Eken was recently named as the medical director for The Child Center at Rogers Memorial Hospital. This residential center provides assessment and treatment for children ages 8 to 13 with psychiatric symptoms.

Rogers Memorial Hospital is Wisconsin's largest, not-for-profit, behavioral health care provider for children, adolescents, adults and older adults. The hospital is nationally recognized for its residential treatment centers including The Eating Disorder Center, Obsessive-Compulsive Disorder Center, The Child Center, and The Child and Adolescent Center. Rogers Memorial also provides residential treatment services for chemical dependency, inpatient and partial hospitalization, as well as day treatment programs.

Rogers Memorial is licensed as a psychiatric hospital by the State of Wisconsin and accredited by The Joint Commission. To learn more, please call (800) 767-4411 or visit us online at **www.rogershospital.org**.

RESEARCH NEWS

Attention Modification Program for the Treatment of Anxiety Disorders

By Sadia Najmi, Ph.D. and Nader Amir, Ph.D.

***Sadia Najmi, Ph.D.**, is a post-doctoral fellow at the Center for Understanding and Treating Anxiety at San Diego State University. Her doctoral dissertation in Clinical Psychology at Harvard University was on techniques for managing intrusive thoughts in OCD, and she completed part of her pre-doctoral clinical internship at the OCD Institute at McLean Hospital. Dr. Najmi is currently involved primarily in the research and treatment of OCD.*

***Nader Amir, Ph.D.**, is the Director of the Center for Understanding and Treating Anxiety and Associate Professor of Psychology at San Diego State University. He has authored over 60 empirical articles and book chapters related to anxiety disorders. Dr. Amir's research is funded by grants from the National Institutes of Health. He provides direct therapeutic services as well as supervises post-doctoral fellows and doctoral students in clinical psychology.*

Over the past 20 years, researchers have shown that anxious individuals tend to focus their attention on negative information. For instance, if they are shown two words or two pictures, one with a negative meaning and one with a neutral meaning, people with anxiety are faster than non-anxious individuals to detect the negative word. We refer to this tendency as an *attentional bias* for threatening information. Over the past seven years, researchers have tried to use this knowledge to create computer programs that attempt to change this tendency, with the goal of reducing anxiety. For example, in a series of studies in our clinic we have shown that a simple computer task, done twice a week for about 20 minutes each for 8-10 sessions, can reduce symptoms of Generalized Anxiety Disorder as well as Social Anxiety Disorder. These results are encouraging because the treatments require very little time and can be delivered in locations where patients may not have access to other forms of treatment.

How does the training of attention work? Most studies of attention training use a task first described in 2002 by Colin MacLeod and colleagues at the University of Western Australia. These tasks are similar to computer games in which letters, words and/or pictures show up on the screen and you are asked to press a mouse button in response to them. However, unlike a computer game, these tasks are designed specifically to draw your attention away from negative information. MacLeod and colleagues found that a single session of attention training resulted in less anxiety when participants were faced with a stressful challenge task.

A few years after that, across various labs, researchers compared the effects of a single-session Attention Modification Procedure (AMP) on responses to a public speaking challenge in a sample of individuals with subclinical social anxiety. Participants in the AMP condition – whose attention was trained *away from* pictures of threatening faces – were compared to participants in a

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placebo condition in which there was no relationship between the location of the probe and the location of the threatening pictures. As predicted, these studies found that those in the AMP group experienced lower levels of anxiety in response to a public speaking task and were judged as having superior speech performance relative to participants in the placebo group. These results suggest that the modification of attentional bias may effectively improve behavioral performance in anxiety-inducing tasks in individuals with subclinical levels of anxiety.

Three studies have now demonstrated that a multi-session AMP – in which attention is trained *away from* threat – can reduce symptoms in clinical samples of patients diagnosed with anxiety disorders. In our lab we have shown that an eight-session AMP was effective in reducing symptoms of Generalized Anxiety Disorder and of Social Anxiety Disorder. Using our procedure, Schmidt and colleagues at Florida State University also showed significantly greater reductions in social anxiety in patients with social anxiety disorder compared to patients in the placebo condition.

Despite this research on attention training in anxiety, researchers have not yet examined whether training procedures such as AMP are capable of treating OCD. We recently examined the effect of a single AMP session on behavioral approach towards feared objects in individuals with subclinical obsessive-compulsive symptoms. Our investigation was limited to individuals with contamination-related obsessive-compulsive symptoms. We hypothesized that training attention away from a contamination-related threat would decrease attentional bias for that threat and that this decrease in bias would lead to a decrease in avoidance of threatening objects (i.e., feared contaminants).

For our study, participants were comprised of 52 individuals recruited from a pool of undergraduate students at our university with an advertisement for individuals who "have concerns about germs, dirt, or contamination." Participants were further screened based on their score on the Cleaning subscale of the Maudsley Obsessive-Compulsive Inventory, a measure of various OCD symptoms. Participants first completed the AMP (or a placebo task), followed by a behavioral approach test (BAT).

We adapted the BAT from a study by Cougle and colleagues. We used three different BATs to assess avoidance of a variety of contaminants. The first BAT consisted of a pile of dirty underwear and other clothes. Participants were told that "some of these items may have been touched with bodily fluids." The second BAT included a mixture of "dirt, dead insects, and cat hair." This mixture was made of potting soil, dead crickets, and cat hair. The third BAT involved a toilet (with an open lid) that was made to look unclean with blotches of potting soil on the inside of the bowl. Each BAT comprised six steps in a graduated hierarchy. If participants were able to complete the first item, they were asked to complete the next one on the hierarchy and if they refused to perform an item, the experimenter terminated that BAT.

Our results demonstrated that, compared to the placebo condition, the AMP was successful in reducing attentional bias for contamination-related threat in individuals with contamination-related obsessive-compulsive symptoms. Moreover, participants who completed the AMP task completed significantly more steps on each of the three BATs than did participants in the placebo group. Thus, consistent with our hypothesis, participants in the AMP group showed significantly greater approach towards a variety of feared contaminants than did participants in the placebo group.

In summary, attention training was effective in reducing attentional bias for threat and increasing behavioral approach towards feared objects in individuals with contamination-related fears. Our results provide support for the effectiveness of attention modification procedures in decreasing observable avoidance behaviors. We are currently in the process of examining a multi-session AMP treatment for patients diagnosed with OCD (any subtype). If replicated in a clinical sample of OCD patients, these findings may have promising implications for the treatment of OCD. The behavioral treatment of exposure with response prevention is considered the psychological treatment of choice for OCD, but a large percentage of patients are either resistant to this form of treatment or refuse it. Our preliminary results from the current study suggest that the behavioral approach required for exposure therapy may be facilitated by attentional bias modification procedures.

If you or anyone you know is in the San Diego area and is interested in participating in this research: We currently have the Attention Modification Program for OCD available free of charge. The program consists of 8 sessions over 4 weeks (i.e., twice a week) for approximately 1 hour each time, plus assessments. There will be monetary compensation for the assessments. In each session, you will complete a computer task that is similar to a reaction time game. We offer the program free because it is still in a research phase—but our preliminary results are promising, and we are trying to improve and further study the program. People who participate are randomly placed into either the treatment or the placebo group. People in the placebo group are offered the active computerized treatment and cognitive-behavioral therapy free of charge at the end of the first 4 weeks. If you are interested in participating, please call (619) 229-3740 or email us at **SDSUCUTA@hotmail.com**.

RESEARCH NEWS

Research Digest

Selected and abstracted by Maggie Baudhuin, M.L.S. and John Greist, M.D.
Obsessive Compulsive Information Center, Madison Institute of Medicine, Inc.

Technology plays a growing part in everyone's lives. For OCD sufferers, technology offers help in several ways. I'm sure that most of you reading this column use the International OCD Foundation's website (**www.ocfoundation.org**) and also search other websites and Internet resources for information pertaining to OCD. Since 1990 the Obsessive Compulsive Information Center has maintained a computerized bibliographic database of the OCD literature. Today, this database contains close to 30,000 references to articles on OCD and OC spectrum disorders and more than 1,500 new references are added each year. Using a computer system to store the OCD literature allows us to search and cross-reference by author, subject, and year of publication, which gives us immediate access to information for the thousands of patients, families, healthcare professionals, and others who contact us each year with their very specific OCD questions and information needs. It is this comprehensive computerized collection that also provides us with the scientific literature reviewed in the OCD Newsletter Research Digests.

Although all of us are familiar with how computers and other forms of technology have dramatically improved the ways we find information, it is important to note how technology is also being applied and further investigated in order to improve patient care.

The main treatments for OCD are cognitive behavior therapy (CBT), emphasizing exposure and response prevention (ERP) and several potent serotonin reuptake inhibitor medications (SRIs) with clomipramine, fluoxetine, fluvoxamine, paroxetine and sertraline having FDA indications for treating OCD. These medications are widely available, as all physicians can prescribe SRIs. CBT is not widely available because, even today, there are very few well-trained cognitive behavior therapists and many patients are required to travel long distances in order to see a therapist. Other barriers for many patients include cost of treatment, lack of insurance coverage, and being unfamiliar with or unaware of this highly effective treatment. Patient surveys have shown that as few as 5% (Torres et al. 2007) and probably not more than one-third (Baer et al. 2008) of patients with OCD have received CBT. How unfortunate! The two definitive trials of CBT versus SRIs versus their combination in adults and children found CBT more than twice as effective as SRIs and the combination of CBT and SRI little better than CBT alone (See Figure 1) (Foa et al. 2005 and March et al. 2004). Further, CBT usually has long-lasting benefits while medications often lose their benefits when stopped. Medications also have greater side-effect burdens including weight gain and sexual dysfunction. This disparity in benefits was recognized more than 30 years before definitive randomized controlled trials confirmed it but, for a variety of reasons, few therapists have been trained to provide CBT. Beyond training more therapists, which the International OCD Foundation does through its Behavior Therapy Training Institutes (BTTIs), how might we overcome some of these barriers so that more patients can get the treatment they need? A number of the studies reviewed below indicate the promise of technology, often computer-administered, to provide CBT that is individualized to guide patients in conducting CBT at convenient times, in their homes and other settings where their OCD problems occur, rather than in therapists' offices, which require commuting and adherence to schedules that may interfere with work and family responsibilities.

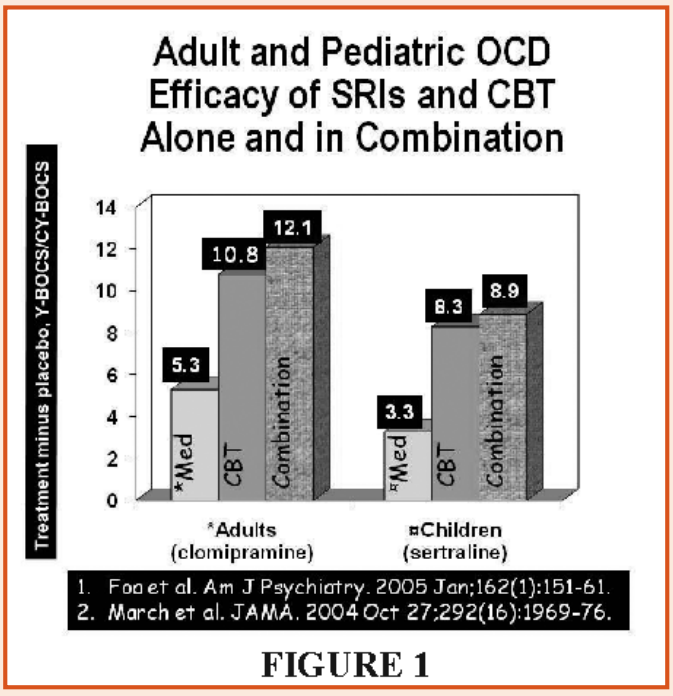

FIGURE 1

This brave new world of technology does not displace excellent clinicians; rather, it permits them to reach and help far more patients than they can during a usual 9–5 work schedule. "Stepped care" is the method involved here. The first step is usually an evaluation performed by a clinician to confirm OCD. The next step is prescription of the computer program which is followed by a step where the patient has ready access to a coach who helps the patient use the program. If the patient isn't progressing (measurements such as distress level and Yale-Brown Obsessive Compulsive Scale are built

into the programs), a therapist can become involved by email, telephone, or face-to-face. Stepped care can permit many more patients to obtain CBT. One concern is that without stepped care, some individuals might not use the computer programs as intended. As with medicine left on the shelf, an unused computer program cannot be helpful.

As you'll see from the studies described below, there are many ways technology is helping OCD sufferers now with a strong promise of more help to come.

Disclosure: Dr. Greist has a proprietary interest in BT STEPS, a program described in some of the articles reviewed in this Research Digest. A web-based version of BT STEPS called CT STEPS has been made available at no cost to patients through physicians by Jazz Pharmaceuticals.

References:
Baer L et al. Reasons for inadequate utilization of cognitive-behavioral therapy for obsessive-compulsive disorder, *Journal of Clinical Psychiatry*, 69(4):676, 2008

Foa EB et al. Randomized, placebo-controlled trial of exposure and ritual prevention, clomipramine, and their combination in the treatment of obsessive-compulsive disorder. *American Journal of Psychia*try, 162(1):151-161, 2005

March JS et al. Cognitive-behavior therapy, sertraline, and their combination for children and adolescents with obsessive-compulsive disorder: the Pediatric OCD Treatment Study (POTS) randomized controlled trial, *JAMA*, 292(16):1969-1976, 2004

Torres AR et al. Treatment seeking by individuals with obsessive-compulsive disorder from the British Psychiatric Morbidity Survey of 2000, *Psychiatric Services*, 58(7):977-982, 2007

A pilot study of telephone cognitive-behavioural therapy for obsessive-compulsive disorder in young people
Behavioural and Cognitive Psychotherapy, 37(4):469-474, 2009, C. Turner, I. Heyman, A. Futh et al.

Based on the results of earlier research showing support for telephone-administered CBT (TCBT) in adults, the authors sought to determine the effectiveness of and patient/family satisfaction with TCBT in younger patients. Ten adolescents, 13 to 17 years old, and their parents participated in this study. These were patients who needed and wanted CBT for OCD, but lived too far away for weekly office visits. Instead of face-to-face sessions in a therapist's office, patients were contacted by telephone on a weekly basis for up to 16 sessions of treatment. Patients were given the same treatment manual used in office sessions, along with worksheets for recording their therapy homework assignments. The Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS) was used to measure treatment outcome. At the end of treatment, there was a significant decrease in OCD symptoms. Seven of the 10 participants (70%) achieved remission (based on CY-BOCS scores of 10 or below), and treatment gains were still present at 12-month follow-up. In addition to treatment response, patients and their parents were questioned about their satisfaction with TCBT. Positive comments were received about the convenience, flexibility, and accessibility of CBT delivered by telephone. For example, less travel time and less time away from work and school made TCBT more convenient than face-to-face treatment sessions. Some found TCBT less stressful than attending a clinic. Also, telephone delivery of CBT provided access to a service that, for some, was not otherwise available to them. In conclusion, this study supports the effectiveness of and patient satisfaction with telephone-delivered CBT in adolescent OCD patients.

The use of computers in the assessment and treatment of obsessive-compulsive disorder
Computers in Human Behavior, 24(3):917-929, 2008, C.W. Lack and E.A. Storch

In this article the authors review studies on the use of computers for both the assessment and treatment of OCD. They provide a history of computer applications for OCD, going back to the mid-1980s, and show how interest in the use of computers has expanded and continues to increase. They describe the various computer applications that have been studied and include in-depth discussions of the computer and interactive voice response (IVR – that use an ordinary telephone as the computer terminal) versions of the Y-BOCS (the widely used patient assessment tool) and of BT STEPS (an IVR computer-assisted behavioral treatment program). They also discuss the many ways computers can be of benefit to both the patient and healthcare provider. For example, they point out that although CBT is a very effective treatment for OCD, there is still a severe shortage of trained behavior therapists and many people must travel long distances in order to see a therapist. Also, the cost of CBT is prohibitive for many individuals. There are also patients who are reluctant to see a therapist. Computer therapy programs can help alleviate these problems. The authors explain how computer versions of patient assessment and screening tools can be of benefit not only to mental health professionals, but also to primary care doctors who are often less familiar with OCD. In their summary, the authors discuss how the research on computers for both assessment and treatment is small in terms of actual published studies, but that study results are very promising in regard to outcome. They emphasize that computer-delivered behavior therapy can certainly be better than no therapy and that, in some studies, computerized therapy has been shown to be as effective as face-to-face treatment with a therapist. One final point they make is that it is important for researchers to consider how computers and related technology such as virtual reality are being used for other anxiety disorders. They feel that it might be possible to improve and expand computer use for OCD by paying closer attention to what has been beneficial for other anxiety disorders.

(continued on p. 20)

RESEARCH NEWS

(Research Digest, continued)

Assessing obsessive compulsive symptoms and cognitions on the Internet: Evidence for the comparability of paper and Internet administration
Behaviour Research and Therapy, 45(9):2232-2240, 2007, M.E. Coles, L.M. Cook, and T.R. Blake

Patient assessment (using patient questionnaires) via the Internet could be beneficial to OCD researchers for a number of reasons. The authors point to several possible advantages including access to a larger, wider, and more diverse group of study participants (including individuals who might not otherwise participate in a study), eliminating travel to the study site, and several other advantages a computer system offers including cost savings, immediate data storage in a searchable database, as well as elimination of errors that can occur with data entry by a research team. To measure the comparability of paper and computer-based assessments, the authors administered two different assessment tools (the Obsessive Compulsive Inventory, which measures OCD symptoms, and the Obsessive Beliefs Questionnaire-44, used to measure OCD-related beliefs) to 105 study participants using paper and pencil and also via the Internet on a secure study website. Participants were randomly assigned as to which version they completed first. Computer experience was also measured in order to determine its impact on test results. An outcome of this study was that the paper and computer assessment tools yielded results that were not significantly different, therefore supporting the equivalence of these methods of administration. Computer experience was not found to influence participants' scores on either assessment tool. The results of this study support the equivalence of paper and Internet administration of these assessment tools. The authors conclude that Internet assessment can provide new opportunities for OCD research online.

Computerised cognitive behaviour therapy for obsessive-compulsive disorder: A systematic review
Psychotherapy and Psychosomatics, 76(4):196-202, 2007, I. Tumur, E. Kaltenthaler, M. Ferriter et al.

The authors cite evidence that cognitive behavior therapy (CBT) is "currently the most effective treatment choice for OCD patients." They note, however, that the shortage of practitioners trained to treat OCD significantly limits access to therapist-led CBT. In this review, the authors examine studies comparing the therapeutic values of computerized cognitive behavior therapy (CCBT) to the therapeutic effectiveness of therapist-led CBT. Specifically they look at four studies, all of which used BT STEPS, a computer-assisted behavior treatment program. In spite of the small number of studies considered in this review and the methodological limitations that the authors acknowledge, they are still comfortable with important conclusions. They believe there is evidence that OCD patients benefit from CCBT, that use of BT STEPS consistently decreases the severity of OCD symptoms, and that CCBT can broaden patient access to convenient treatment. CCBT, they conclude, is "as good as therapist-led CBT in decreasing daily time in rituals and obsessions and work/social disability." They recommend that further randomized controlled trials (only two of the four reviewed here were RCT studies) be conducted and that future studies should consider such things as gender, age, and socio-economic status, and they should focus upon establishing guidelines regarding the optimal conditions for CCBT as well as the extent to which therapists might be involved.

Anxiety provocation and measurement using virtual reality in patients with obsessive-compulsive disorder
CyberPsychology & Behavior, 11(6):637-641, 2008, K. Kim, C.H. Kim, K.R. Cha et al.

Although virtual reality programs (technology that simulates real environments that people can interact in and with) have been developed to study and treat several other anxiety disorders (fear of flying, fear of heights, panic disorder, PTSD, and others) very little research on virtual reality (VR) for OCD has occurred. Beginning in the late 1990s, Kenneth Kirkby and colleagues studied what they referred to as "computer-aided vicarious exposure" for OCD. These studies had patients interact with an animated "environment" for exposure to dirt as a treatment for hand-washing rituals. Instead of being immersed in the virtual environment, patients directed animated characters on a screen for both exposure and ritual prevention.

In the last several years we have seen enormous technological advancements that have led to the creation of very sophisticated VR treatment programs in which patients can feel as though they are actually in and interacting with the virtual environment. In this current study by Kim et al., the effect of VR on checking behaviors was tested in 33 individuals with OCD and 30 control subjects. The authors' main objective was to determine if VR can provoke or induce anxiety in OCD patients, since heightened anxiety and anxiety variation are important components of actual exposure. The participants used head-mounted displays to experience a virtual environment in which they would get up and get ready for work. Each participant had to perform certain tasks such as turning on a light switch, opening a window, opening the door, turning on a gas burner, and using the water. Before they "left for work" in this virtual environment, they were instructed to check, just as they would in their real life, to make sure that everything was as it should be before leaving. They were allowed to check as much as they wanted before leaving. While in the virtual environment, the OCD group reported higher anxiety than the control group, and they spent more time checking than the controls. It was also noted that decrease in anxiety was more rapid for those in the OCD group compared to controls. These results suggest that VR can provoke anxiety in OCD patients, meaning that VR shows promise for study and possibly treatment of OCD. The authors refer to their study as "the first step in the treatment of OCD using VR."

Research Participants Sought

African-Americans with Obsessive Compulsive Disorder (OCD)
The University of Pennsylvania is conducting a study of African-Americans with Obsessive Compulsive Disorder (OCD). Recent research shows that African-Americans with OCD are not getting the most effective treatments. If you have OCD, we want to learn more about what this has been like for you and if you have ever tried to get help for your symptoms.

Participants will receive a psychological evaluation, discussion of treatment options, and $100 in compensation. The evaluation will involve completing some questionnaires and an interview with a professional clinician. No physical exam is required (i.e., no shots, needles, x-rays, or pills). Call our office at (215) 746-3327 for a confidential phone screening to determine if you are eligible and ask for Samantha Farris. You can also visit our website at **www.black.ocdproject.org**.

Not sure if you have OCD? Call our center for a phone pre-screening. You may have OCD and not even know it!

PI: Monnica Williams, Ph.D.
Center for the Treatment and Study of Anxiety University of Pennsylvania School of Medicine; 3535 Market Street, 6th Floor; Philadelphia, PA 19104

IRB Approval: #810175

Have you been diagnosed with severe OCD?
If the answer is yes and you are between the ages of 18 and 65, you may be eligible to participate in a new NIMH-sponsored study. We are looking for both participants who may be interested in considering a neurosurgical treatment for OCD, as well as those who may be interested in participating in an adjunct study (without surgery) examining the relationship between the brain and behavior in OCD.

If you would like more information about neurosurgical treatment for OCD, please contact either Rich Marsland, RN at (401) 455- 6211 or **rmarsland@butler.org** or Jennifer Bernier, BA at (401) 455-6366 or **jabernier@butler.org**. If you are interested in the non-surgical adjunct study, please contact Jennifer Bernier, BA at (401) 455-6366 or **jabernier@butler.org** or Nicole C. McLaughlin, PhD at (401) 455-6608 or **nmclaughlin@butler.org**.

Does your child or teenager have Obsessive Compulsive Disorder?
We are conducting a research study to examine how cognitive-behavioral therapy delivered via videophone works in reducing Obsessive Compulsive Disorder (OCD) symptoms in children and adolescents. Past research has found that CBT is helpful for as many as 85% of children with OCD. However, many people do not have access to CBT – therefore, videophone-administered CBT may be a way to make treatment more convenient and affordable (less travel costs) and less time-consuming.

Your child must be between the ages of 7-17 and have problematic OCD symptoms to be able to participate in this study. If he/she is eligible to participate in this study, he/she will either receive videophone-CBT right away or after a 4-week waiting period. This study will involve 14 90-minute sessions of videophone-CBT (twice a week for the first 4 sessions) and 5 psychiatric evaluations of varying lengths. Study treatment and evaluations will be provided at no charge.

If you are interested or have questions, please call Dr. Eric Storch at (727) 767-8230 or email him at **estorch@health.usf.edu**.

Examining Specific and Core Beliefs in Body Dysmorphic and Obsessive Compulsive Disorders
You are invited to participate in a study examining specific and core beliefs in adults (18 +) with Body Dysmorphic Disorder (BDD), Obsessive Compulsive Disorder (OCD) and controls. By investigating the specific and core beliefs in BDD and OCD, this will assist in developing more tailored and effective cognitive-behavioral treatment for these sometimes debilitating disorders. By participating in this study, you will get a free diagnostic test and will help us gain insight into the cognitive nature of BDD and OCD. Any adult (18 years or older) is welcome to participate, particularly individuals with BDD or OCD diagnoses. If interested in participating or for further information please call (516) 487-7116 and ask for Agnes. You can also email her at **selinger@biobehavioralinstitute.com**. This study is held at the Bio-Behavioral Institute in Great Neck, NY.

Online Survey for Parents of Children with Trichotillomania
Researchers at the University of Wisconsin-Milwaukee (Dr. Doug Woods and his colleagues) and members of the TLC Scientific Advisory Board are interested in learning more about the impact that Trichotillomania has on young children who pull their hair. These researchers have created a survey for parents with a child who pulls their hair. Children who are currently 10 years of age and younger are being studied in this survey. The survey is anonymous and is intended to be completed online. The researchers would greatly appreciate your time and effort to complete the survey. It is hoped that this information will lead to a better understanding of Trichotillomania in young children and, ultimately, to more effective treatments. If you are interested in participating in the survey, please visit the website below, which will take you directly to the survey: **https://www.surveymonkey.com/s.aspx?sm=QIdUltqEOc8rWZAOmZt6_2bQ_3d_3d**

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RESEARCH NEWS

(Participants Sought, continued)

Imaging the Serotonin System in OCD

Principal Investigator: Dr. H. Blair Simpson

To schedule a confidential screening in the New York Metropolitan area, contact: Dr. James Bender Jr. (212) 543-5462 or Rena Staub (212) 543-5380.

Overview of Study:
The study examines whether the brain serotonin system is different in patients with obsessive-compulsive disorder (OCD) than in those without OCD. One of the brain serotonin receptors will be measured using a standard imaging procedure called positron emission tomography (PET). An anatomical picture of the brain using magnetic resonance imaging (MRI) is also done. Subjects are compensated $500 for their participation and offered three months of OCD treatment at no cost to them.

Eligibility:
- 18-55 years, both genders

Key Inclusion Criteria:
- OCD is the primary problem.
- Not currently on psychiatric medications.

Key Exclusion Criteria:
Current medical or neurological problem that would make participation hazardous

Who is this study for?
For people with OCD who are not on psychiatric medications and who would like to help us answer the scientific question of whether their brain differs in this way from people without OCD.

Maximizing Treatment Outcome in OCD

Principal Investigator: Dr. H. Blair Simpson (Columbia University-New York State Psychiatric Institute)/ Dr. Edna Foa (University of Pennsylvania)

To schedule a confidential screening, contact: New York Metropolitan area: Dr. James Bender Jr. (212) 543-5462 or Rena Staub (212) 543-5380.

Philadelphia: Center for the Treatment and Study of Anxiety (215) 746-3327

Overview of Study:
This study compares the effectiveness of two proven treatment strategies for OCD patients who are currently on a serotonin reuptake inhibitor medication (SRI, i.e., clomipramine, fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram, or escitalopram) but still have residual symptoms. Participants remain on their current medication and receive either cognitive-behavioral therapy (CBT) consisting of exposure and ritual prevention or an additional medication (risperidone).

The goal of the study is to compare risperidone against cognitive-behavioral therapy as add-on treatments, each of which has been found effective in prior studies. All treatment is at no charge. Note: Patients who do not improve after 8.5 weeks of treatment will be offered at no-cost the treatment they did not initially receive (either the therapy or the add-on medication).

Key Eligibility Criteria:
- 18-70 years; both genders

Key Inclusion Criteria:
- OCD is the primary problem
- On a stable dose of a serotonin reuptake inhibitor medication

Key Exclusion Criteria:
- Medical or psychiatric conditions that would make study participation hazardous
- Patients who have already had an adequate trial of these augmentation strategies while on a serotonin reuptake inhibitor

Who is this study for?
OCD patients on medications who still have bothersome symptoms and who have not previously received an adequate trial of these proven add-on strategies.

For more information about this study, please visit **www.ocdproject.org**.

Does your child or teenager have Obsessive Compulsive Disorder?

The Rothman Center of Pediatric Neuropsychiatry is recruiting subjects to participate in a study designed to monitor and assess the relationship of dosing strategies of sertraline to behavioral side effects such as increased activity level or worsening mood. If you participate, your child will receive either study medication or a pill placebo. All participants will receive 14 sessions of cognitive-behavioral therapy. To participate, your child must be 7-17 years of age and have obsessive compulsive disorder. All research procedures will be provided free of charge.

If you are interested or have questions, please call Jeannette Reid at (727) 767-8230 or email **rothmanctr@health.usf.edu**.

Trial of Paliperidone Addition in SRI-Resistant OCD

Have you been diagnosed with OCD and not responded to past medication or counseling treatment? If so, you might be eligible for a study at the University of South Florida examining if adding a medication called Paliperidone helps reduce your OCD symptoms.

To be eligible, you must be at least 18 years old and have problematic OCD symptoms despite having tried at least two OCD medications. 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 (Paliperidone) or a sugar pill in addition to the medication you are currently taking. There will also be eight psychiatric evaluations that take place. Study medication and evaluations will be provided free of charge. Participants will also receive financial compensation for their time.

If interested, please call Dr. Jane Mutch at (727) 767-8230 or email **rothmanctr@health.usf.edu.**

THE INTERNATIONAL OCD FOUNDATION
2010 RESEARCH AWARDS
REQUEST FOR PROPOSALS

Submission Period:
November 30, 2009 – February 12, 2010
at 5pm EST

The International OCD Foundation is committed to finding and promoting effective treatment for everyone. To further this mission the Foundation is interested in funding research into the brain, its chemistry, structure and functioning; basic neurobiology; the genetics of OCD; its epidemiology; and all aspects of OCD and the OC Spectrum Disorders that will lead to prevention and treatment advances.

The Foundation has been awarding research grants since 1994. Since then, it has funded over $2,700,000 in OCD research.

For application guidelines and submission information, please check the OCDF website later this Fall:
http://grants.ocfoundation.org

FROM THE AFFILIATES

Affiliate Updates

CALIFORNIA

OCDF of San Francisco Bay Area Participates in Local Hoarding & Cluttering Conference

The Mental Health Association of San Francisco's Annual Conference on Hoarding and Cluttering will be held on November 5, 2009 at St. Mary's Cathedral in San Francisco, CA. The keynote speaker will be Tamara L. Hartl, PhD. This annual conference attracts more than 400 social service providers, medical professionals, landlords and property managers, researchers, family and friends, and people who hoard and clutter. The OCDF of San Francisco Bay Area affiliate has participated in the planning and will be exhibiting at the conference.For registration and other information go to the MHA-SF website: **http://mha-sf.org/programs/hcconf.cfm**

MASSACHUSETTS

OCF of Greater Boston Announces 2009-2010 Lecture Series Dates

The OCF of Greater Boston, in conjunction with McLean Hospital, presents a series of preeminent speakers in the field of OCD and related disorders. Each presentation takes place from 7–8pm in the De Marneffe Cafeteria Building, Room 132, at McLean Hospital in Belmont, MA.

Obsessive Compulsive & Related Disorders Les Grodberg Memorial Lecture Series 2009 – 2010

Sponsored by the Greater Boston Affiliate of the International OCD Foundation

November 3, 2009 Families of Adult Children with OCD	Perrie Merlin, LICSW McLean Hospital OCD Institute
December 1, 2009 OCD 101 for Consumers and Families	Laura Ferrer, PhD McLean Hospital/Harvard Medical School
January 5, 2010 An Update on the Genetics of OCD	Evelyn Stewart, MD Massachusetts General Hospital Harvard Medical School
February 2, 2010 What if I Have Social Anxiety and OCD?	Jason Elias, PhD McLean Hospital OCD Institute
March 2, 2010 Coping Skills for People with OCD	Thröstur Björgvinsson, PhD McLean Hospital/Harvard Medical School

NOTE: Please check **www.ocfboston.org** for information on changes to the schedule or cancellations.

Following each speaker presentation, there are several free self-help groups open to the public. For information on support groups please contact Denise Egan Stack at (617) 855-2252. The groups will begin at 8pm and run until

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FROM THE AFFILIATES

(Affiliate Updates, continued)

approximately 9:30pm in rooms 114 and 132 in the De Marneffe Cafeteria Building. The identity of participants and content of group discussion must remain confidential. Furthermore, if desired, you may remain anonymous. We remind participants to be open and supportive to the views of all those who take part in the support groups.

MINNESOTA

OCD Twin Cities Website Is Now Live

OCD Twin Cities is excited and proud to be the newest affiliate of the International OCD Foundation and a non-profit foundation serving the Twin Cities community of individuals with obsessive compulsive disorder and related disorders, their families, friends, mental health professionals, and other concerned individuals.

Our mission is to create awareness, provide resources for individuals with OCD and their family and friends, educate the public and professional communities about OCD, and improve quality of treatment and access to resources for individuals with OCD.

Log on to our new website (**www.ocdtc.org)** to learn more, connect with us through Facebook or Twitter, or call us at (651) 775-9678 to get involved.

NEW JERSEY

New Jersey OCF Affiliate Holds 10th Annual Conference in October

On October 25, 2009 the New Jersey OCF Affiliate will be having its 10th Annual Brunch/Conference at the Doubletree Hotel in Somerset, NJ. This year's Conference will feature Dr. Fugen Neziroglu, who will give a talk on 'Body Dysmorphic Disorder (BDD), Hypochondriasis, Hoarding, and other OCD Spectrum Disorders' and 'Comparing and Contrasting Treatments with OCD.'

As in previous years there will also be a 'Living with OCD' panel, featuring about a half dozen adults, adolescents, and/or children with OCD or their family members who will discuss their experiences and take questions from the audience.

This Annual Conference/Brunch has typically been attended by both professionals and laypeople. Past presenters have included Drs. Marty Franklin, Fred Penzel, Jonathan Grayson, Charles Manseuto, and Jonathan Abramowitz.

The New Jersey OCF Affiliate also holds quarterly meetings which are free and open to the public and which also feature a speaker/presenter. On Monday, December 14, 2009 Dr. Cindy Haines of the Stress and Anxiety Services of NJ will be the presenter – specific topic to be determined.

PENNSYLVANIA

OC Foundation of Western PA Announces its OCD Awareness Week Events

The OC Foundation of Western PA (OCF/WPA) has a week of events planned for OCD Awareness Week. We hope that you will be able to join us for at least one of our activities and will help us spread the word to others who may not receive a direct notice of the schedule.

Monday, October 12

During the day, Elaine Davis, PhD and Tamara Heckel, LCSW will be offering professional training sessions at the Allegheny County teacher in service conference on 'OCD in the Classroom.' Drs. Hudak and Shear will be lecturing at a continuing medical education session in the evening for local psychiatrists. *These events are only open to members of the groups sponsoring the respective conferences but we wanted to let you know that we are hard at work!*

Tuesday, October 13

6:00pm *Pizza Party*
Safe Harbor Behavioral Health
1330 West 26th St, Erie, PA
Open to everyone with OCD as well as their family/friends. The evening will allow everyone to meet in an informal setting. Kids will have time to get together separately from the adults. Adults with OCD, parents, and other family/friends will be able to meet each other and participate in a question and answer session with local OCD adult, child and family therapists as well as a psychiatrist.

Wednesday, October 14

6:00pm *OCD Support Group*
155 N. Craig St., Ste 170, Pittsburgh, PA
This is a regularly scheduled support (not therapy) meeting open to anyone whose life has been touched by OCD as well as mental health professionals who are interested in exploring support group dynamics.

Wednesday, October 14

7:30pm *Documentary Showing*
Bellefield Towers, Conference room
100 N. Bellefield Ave., Pittsburgh, PA
A showing of the ABC Primetime 'Family Secrets – OCD' episode, which did not air in the Pittsburgh market in August, with popcorn provided. Co-sponsored by the OCD Intensive Treatment Programs of the UPMC Western Psychiatric Institute and Clinic and the OC Foundation of Western PA.

Thursday, October 15

Resolve Crisis Network
333 North Braddock Ave.,
Pittsburgh, PA
6:30pm *Annual Open Board Meeting*

Designed to update our membership on the goals we have accomplished in the preceding year and what activities we are working on for the upcoming year.

7:00pm *OCD Behavioral Treatment: How Intense a Protocol is Right for Me?*
Terri Laterza, LCSW; Kalie Pierce, MSCP
Open seminar with light refreshments available. This lecture will include an introduction on OCD and medication concerns by Robert Hudak, MD.

We would also like to make everyone aware that the **3rd Annual Dirt Monster 5 Mile Trail Race and 1 Mile Trail Walk** is coming up on Saturday, November 7 at 9:30am in North Park. Registration is available online at **www.ocfwpa.org** and we welcome volunteers to help out the morning of the race; no experience necessary.