INTERNATIONAL OCD FOUNDATION

OCD Newsletter

Volume 24 Number 2 Published by The International OCD Foundation, Inc. Spring 2010

FROM THE FOUNDATION

New Features and Exciting Sessions Highlight 17th Annual IOCDF Conference in Washington, D.C. this July

"Effective Treatment for Everyone" is the goal of the International OCD Foundation and is at the heart of our 17th Annual Conference being held July 16-18, 2010 at the Hyatt Regency Crystal City just outside of Washington, D.C. We recognize the differing needs of our attendees and, with this in mind, have attempted to provide each of them with the tools to meet this goal. We trust that those of you with OCD or an OCD Related Disorder, as well as friends, family members, therapists and researchers, will find the Conference helpful. It is our hope that you will learn new things, meet others in a similar situation, and feel more empowered to tackle the challenges you face every day. Each year we try to build on the strengths of this Conference as well as add new elements, and we are confident that you will be pleased with what we have in store for you this year.

IN THIS ISSUE

Visit our Conference website to view a Google Calendar that includes descriptions of every single Conference session!

FROM THE FOUNDATION

2-Day Treatment Group *July 14 & 15, 2010*

This year, in response to feedback from previous Conference attendees, individuals with OCD who might otherwise not be able to visit a specialty OCD clinic will get a chance to experience an intensive 2-day treatment program prior to the Conference. On July 14-15, Dr. Reid Wilson, co-author of *Stop Obsessing!* and author of *Don't Panic!* will be running a 2-day treatment group for people with OCD. Space is limited to eight participants. Dr. Rick Baither, a psychologist with the Northern Virginia Psychiatric Group, will be assisting Dr. Wilson in this workshop. The cost of the program is just $375 and Dr. Wilson is generously donating 100% of the funds back to the IOCDF. To download a registration and referral form, visit **http://anxieties.com/pdf/registration.pdf**. For questions about the program, please contact Dr. Wilson directly at **rrw@med.unc.edu** or (919) 942-0700.

The International OCD Foundation is pleased to announce this year's Advanced Behavior Therapy Training Institute (ABTTI) topic:

Treating Religious Obsessions: Helping the Scrupulous Contend with Certain Uncertainties About the Uncertain Certainty

C. Alec Pollard, PhD
Director, Anxiety Disorders Center
St. Louis Behavioral Medicine Institute
St. Louis, MO

July 15, 2010
1:00-6:00 PM
Hyatt Regency Crystal City
Arlington, VA

Held on the afternoon before our Annual Conference, the Advanced Behavior Therapy Training Institute (ABTTI) is a five-hour training session exclusively for mental health professionals. 4.5 contact hours. Additional $100 registration fee. Space is limited. Visit **www.ocfoundation.org/conference.aspx** for more information or to complete your registration today.

OCD Film Festival *July 15, 2010*

Are you arriving in D.C. early? If so, you might be interested in attending our first ever "OCD Film Festival." Four films will be shown on the evening of Thursday, July 15 and are free for Conference attendees. Tickets will be available on a first-come, first-served basis only. Screening times and ticket information will be available at the registration desk on Thursday. Our featured films will be:

- "Information About Compulsive Hoarding" by Dr. Renae Reinardy, Vice President of OCD Twin Cities
- "The Touching Tree" by James Callner of the Awareness Foundation for OCD and Related Disorders
- "OC87: The Obsessive Compulsive, Major Depression, Bipolar, Asperger's Movie" by Bud Clayman
- "PeaceLove is Possible" by PeaceLove Studios

OCD Newsletter
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The International OCD Foundation (IOCDF) 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.

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

Program Highlights *July 16-18, 2010*

For Family Members of those with OCD and Related Disorders

- "Life with OCD: Elizabeth McIngvale's Family Perspective" – Presented for the first time last year to a standing-room only crowd, Elizabeth McIngvale will again share her life story and struggles with OCD, from her diagnosis at age 12 to where she is now. Her mother Linda and sister Laura will give a family perspective on what it is like to live with a loved one with OCD.
- "Working Together to Quiet OCD" – This workshop will help attendees identify and target common themes and patterns of behavior that are present in families dealing with OCD. Dr. Barbara Van Noppen, Constantina Boudouvas, and Dr. Michele Pato, along with several other group leaders, will lead an experiential workshop for families to learn how to use behavioral contracting to reduce the impact of OCD symptoms on personal and family functioning while fostering a supportive environment for ERP.
- "Couples Against OCD" – Harriet R. Thaler, LCSW, LMFT, will lead an experiential workshop intended to involve both individuals with OCD and their partners. The focus of this session will be on ways to diminish and defeat the power and control of OCD in a relationship. This will be done by heightening awareness and developing skills toward improving interactions and building trust and intimacy in a relationship.

For Kids and Teens with OCD and Related Disorders

This year we have an entire track dedicated to kids and teens with OCD and related disorders. Highlights include:

- Kids and Teens Art Therapy Rooms – Jenifer Waite-Wollenburg and Katy Peroutka, two art therapists from Rogers Memorial Hospital, will be supervising and facilitating art, leisure, and socialization processes in the activity rooms for kids (younger than 13) and teens (ages 13-18) throughout the Conference. This year's art therapy rooms will be held in memory of Michael Luchini.
- "2nd Annual IOCDF Fashion Show and Karaoke" – Participants in this interactive workshop will get an ERP-based makeover and compete in the OCD Fashion Show. With the support of fellow attendees and their cheering fans, models on the catwalk and the OCD singers will learn how to fight OCD and think about exposure exercises in a whole new way.
- "OCD: The Game Show for Kids" – Kids, join the fun at your very own game show! Contestants chosen from the audience will have the opportunity to win prizes by demonstrating their knowledge of OCD, and then competing in games of skill, chance, and courage, all reflecting the OCD theme.

For Adults with OCD and Related Disorders

- "Turning Points and Hope" – Jeff Bell will moderate a panel of OCD success stories featuring Elizabeth McIngvale, Jared Kant, Shannon Shy and Chris Trondsen.
- "OCD in the Media" – One of our most popular sessions last year, this panel includes Shana Doronn of A&E's "Obsessed," Robin Zasio of A&E's "Hoarders" and Elizabeth McIngvale of VH-1's "The OCD Project."

(continued on p. 4)

FROM THE FOUNDATION

Program Highlights *July 16-18, 2010*

For Mental Health Professionals

This year's Conference will feature 34 professional sessions, ranging from introductory to advanced content. Highlights include:

- "Enhancing Treatment Outcomes for Difficult to Treat OCD: What, How and With Whom?" – Drs. Edna Foa and Elna Yadin will use clinical case presentations from adults, adolescents and children to help identify barriers to treatment, provide some strategies to address them, and increase the flexibility in treatment options.
- "Careers in OCD: Which Path Makes Sense for Me?" – Led by Dr. Lisa Bertman-Pate, this moderated panel of experienced OCD therapists will assist students, recent graduates, and young therapists by discussing different paths to follow for pursuing a career in OCD. The primary goal is to help individuals tailor a career track in OCD based on their current training and circumstances. The panel will consist of seasoned clinicians and researchers who will offer different perspectives on ways to obtain training and experience with OCD and related disorders.
- "Surgery for OCD: 2010" – For the researchers in attendance, Drs. Darin Dougherty, Ben Greenberg and Nicole McLaughlin will describe the state of the art data about the outcomes of the main surgical approaches to otherwise intractable OCD: cingulotomy, gamma ventral capsulotomy, and deep brain stimulation. The risks and burdens of the surgeries will be presented as well as their possible benefits.

Evening Programs

July 16 & 17, 2010

On Friday evening we will hold nine support groups on topics including:

- OCD in older adults
- Scrupulosity
- BDD
- Compulsive hoarding
- GOAL
- Intrusive thoughts
- Obsessive Compulsive Anonymous
- Parents of children with OCD
- Teens and young adults with OCD

The support groups will be followed by Dr. Jonathan Grayson's 10th Annual Virtual Camping Trip. The trip will begin with a very brief presentation about Dr. Grayson's camping trips and how they can inspire you to risk getting better. Following this, participants will go on a field trip throughout Washington, D.C., during which they will experience the exhilaration of conquering OCD fears in a group. Everyone will be encouraged to support and help one another, but participants will have full control over what they decide to do. The surprise will be in how much more you will choose to do during this adventure.

We have also expanded the number of Saturday night programs available to attendees. In addition to our Saturday evening social and dancing, we will also offer several other options, including a play called "Disorder" by Hilary Kacser, art therapy by PeaceLove Studios, and two additional support groups.

If you register for the Conference online, be sure to use the Member ID# that is printed above your name and address on the outside of this newsletter.

Patti Perkins Lifetime Achievement Award and Keynote Address

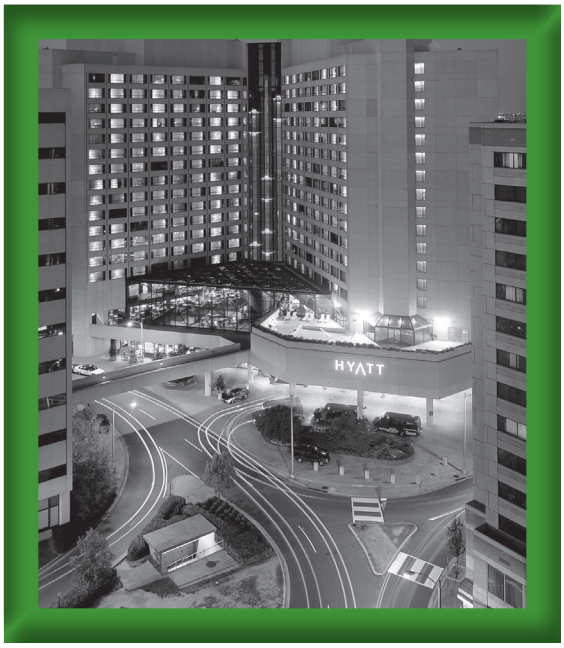
July 17, 2010

Each year the IOCDF's Board of Directors recognizes an individual who stands out as having contributed to the success of the IOCDF's mission and programs. This year, we will honor the contributions of Dr. Jonathan Grayson. Dr. Grayson has spent the last 30 years treating individuals with OCD and is currently the director of the Anxiety and OCD Treatment Center of Philadelphia. Dr. Grayson has been a member of the IOCDF's Scientific Advisory Board since 1999 and has been on the Advisory Board of the OCD Philadelphia affiliate since 1989, currently as the chair. Dr. Grayson presented at the very first IOCDF Annual Conference in 1993 and has given nearly 60 talks and workshops at our Conference since then. Dr. Grayson was also a member of the Program Committee from 2000-2007, helping to shape the content and direction of the Annual Conference from year to year. Dr. Grayson is a regular contributor to the OCD Newsletter, was involved in helping to develop the IOCDF's "OCD in the Classroom" kit, and has helped to shape and influence support groups for individuals with OCD. In fact, in 1981, along with Gayle Frankel, he started the first support group in the country for OCD. Dr. Grayson is also a member of our Speakers Bureau and a Faculty member of our Behavior Therapy Training Institute. We are very excited that Patti Perkins will be on hand to present this award to Dr. Grayson before the Keynote Address.

We are thrilled to announce that Shannon Shy, a retired Lieutenant Colonel in the Marines will deliver this year's Keynote Address entitled, "My War with OCD: A Story of OCD in the Military." With the Pentagon just over a mile away from the Conference hotel, we felt that Lt. Colonel Shy's personal experience with OCD while on active duty, as well as the treatment he received that helped him succeed, made him an ideal choice for this year's Keynote speaker. He is currently a senior civilian attorney with the Department of the Navy and author of *"It'll be Okay": How I Kept Obsessive-Compulsive Disorder (OCD) from Ruining My Life*. In 2007 he retired from the Marine Corps Reserve as a Lieutenant Colonel, receiving the Legion of Merit Medal upon his retirement. In 2009, Shannon received the Department of the Navy's Distinguished Civilian Service Award, which is the highest honorary award the Secretary of the Navy can confer upon a civilian employee.

Hotel Information

All Conference sessions and social functions will be held at the Hyatt Regency Crystal City (located at 2799 Jefferson Davis Highway in Arlington, VA). A limited block of rooms has been set aside at a special rate of $119/night. Reservations can be made directly by going to **https://resweb.passkey.com/go/OCF** or by calling (701) 418-1234 and mentioning the International OCD Foundation Conference. This special room rate will expire on June 24, 2010, so please be sure to book your room before then.



To view the entire Conference program, learn more about the Annual Conference and host city, or to register online, visit: **www.ocfoundation.org/Conference.aspx**

FROM THE FOUNDATION

Message from the President

Dear Friends,

With the arrival of spring there continue to be new and exciting changes happening at the IOCDF. We are incredibly excited about our 17th Annual Conference taking place in Washington, DC this July. We have yet another fantastic program lined up for everyone, and we are expecting another record-breaking year in terms of attendance and hope to see both old and new attendees there. Please be sure to read IOCDF Program Director Michael Spigler's front page article, which gives you all of the information you will need to know about the Conference.

The submission period for the 2010 IOCDF Research Grants has come to a close and our Grant Review Committee is currently reviewing proposals. Yet again, we received so many impressive submissions for this year's grant cycle that choosing which ones to fund will be a difficult process. It is wonderful to see the progress that continues to be made in this field by so many talented researchers. Thanks to all of you who donate to our Research Appeal – it is only through your generosity that this important research is made possible. The Grant Review Committee will make their final proposal recommendations in April, and the final decisions about the grant recipients will be made during our Board of Directors meeting in May. The winners will be announced on our website by early June and in the next issue of the OCD Newsletter, which members should expect to receive toward the end of August.

We are also excited to participate as an exhibitor at the 6th World Congress of Behavioral and Cognitive Therapies on June 2nd-5th. The Congress is being held right here in Boston, MA and will be hosting speakers from all over the world. In keeping with our goal to continue to form partnerships with groups on an international level, this will be an exciting opportunity for us to solidify existing relationships and reach out to new organizations from around the world that share common goals.

Finally, I want to update our members with some of the exciting changes that have been taking place in the national office. Rebecca Cyr, who began as an Administrative Assistant in February 2008 during the IOCDF's first days in Boston, has been promoted to Assistant Program Director. We are now putting Rebecca's incredible organizational skills to better use by having her more involved with Conference and BTTI planning and coordination, acting as the Newsletter Editor-in-Chief, and supervising office volunteers. We have also hired a new Financial Manager, Pam Lowy. Pam comes to us with 9 years' experience in international project management and event planning, including 7 years' experience working abroad in multinational organizations. Emma Etheridge is our new Receptionist. A fluent Spanish speaker, Emma spent a year as a Fulbright English Teaching Fellow in Venezuela after graduating from Trinity College in Hartford, CT. Emma has quickly learned the ropes in the office and, as I'm sure those of you who have spoken or emailed with her know, has a warm and inviting attitude. Finally, we have recently hired a consultant as a Web Developer. Fran Harrington, who graduated from the New England Institute of Art, has both web development and graphic design experience. Fran will be instrumental in helping us take our new website to the next level. We are so fortunate to have such a talented group running our office.

Please make sure to share your feedback about the changes you are seeing with the Foundation. We value your opinions about what we do and how we can improve the services we offer. We truly want to make the Foundation work better for all who need it.

We hope to see you this summer in Washington!

Diane Davey
President, IOCDF Board of Directors

FROM THE FRONT LINES

Spirituality: Real Medicine for Mental Illness

By James Callner

James Callner, MA, is President of the Awareness Foundation for OCD and Related Disorders ***(www.afocd.org****), a professional speaker on OCD, and an award-winning filmmaker (for 'The Touching Tree').*

"Who Knew?" – a phrase my Jewish relatives instilled in me decades ago. Who knew that spirituality would be the strongest, most lasting medicine for my mental illness? Who knew that reclaiming and cultivating the damaged spirit within me would calm the trauma of anxiety, panic and depression?

In 1982 at age 29 I had a devastating nervous breakdown and was hospitalized in a psychiatric ward for six weeks. I became fearful of living. Sound scary? It was beyond scary.

When my full onset hit in 1982, my symptoms were classic OCD such as washing, checking, counting, obsessions about harming, etc. The primary symptom I experienced was phobia of germs and contamination. I wouldn't let anyone touch me for fear of passing on or receiving germs. I would spend nine hours each day washing my hands, and I had bathroom rituals that took up to four hours per day. I was overtaken by fear of virtually all my surroundings.

I had lost my job, my relationship, my apartment, and my life. I remember my psychiatrist telling me that this would be the greatest journey of my life. I couldn't help but ask: When does it end? When does this great journey find peace? When will it all stop? I was willing to do anything to make it stop!

Recovery began with anti-anxiety medication so I could begin the long process of Exposure and Response Prevention (ERP). But once I could lean on ERP to help ease my symptoms, what was there to help balance my emotional life? What was there to bring serenity and peace back to a life of stress and fear? What I found was something that I would never have thought of approaching. This nice liberal Jewish boy from Wisconsin was about to enter the realm of Spirituality.

The Spirituality I am talking about is not religious in nature. It does not come from any religious denomination or sect. It is a spirituality that is about reclaiming one's broken, damaged spirit. Mine needed extreme mending! It all started when my psychiatrist suggested I be around "like-people." He recommended going to a 12 Step group.

At that time, Obsessive Compulsive Anonymous was virtually nonexistent in my area. My psychiatrist suggested I go to Al-Anon. I said to him, "Now wait a minute, I don't think so. There's nobody in my family that is an alcoholic, so why are you suggesting Al-Anon? I have OCD." He sat back in his chair with a gentle smile and said, "The first step of all 12 step programs reads the same except for one word. For instance, in Alcoholics Anonymous it will read, 'We admitted we were powerless over alcohol - that our lives had become unmanageable.' In Codependents Anonymous it will read, 'We admitted we were powerless over others - that our lives had become unmanageable.'" Then he looked at me with his soft nonjudgmental eyes and asked, "Jim, what are you powerless over at this time in your life?" I replied, "My fears; the OCD." He agreed and continued to ask me these bottom-line questions. "At any level, has your life become unmanageable or out of control?" I thought for a few seconds. Bang! It all made sense. I had no control over my fears from OCD and my life was a mess because of it. He then he asked the crucial question: "Jim, in that first step, do you think you could replace that single word with 'fears?'"

So, on a Wednesday night, I went to my first 12-step meeting. In the beginning I found myself internally fighting with the program and all those slogans and ideas that made absolutely no sense to me, like "Let Go, Let God." My brain screamed silently, "What the hell is that supposed to mean?"

I went back to my psychiatrist and asked, "What the hell does 'Let Go, Let God' mean?" He replied with words that I carry to this day. He said plainly, "All it means is, 'Stop Trying to Figure It Out.'"

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FROM THE FRONT LINES

(Spirituality, continued)

Stop trying to figure what out? It was my choice. The Source, the Universe, the ocean, the higher power in me, etc. It was my choosing. For the first time in my life I got very, very quiet and literally stopped talking. The Committee in my mind stopped arguing. Something finally made sense. For decades I had been trying to figure out life, rather than live it.

But then my brain snapped back into judgment mode. It sounded just too simple for a person so phobic and fearful. I said to him in a defensive voice, "Stop trying to figure it out? And then what?" He replied with another life changing spiritual concept: "And then, let go of controlling all your feelings and fears. Have them. Own them. Feel them. Life is about feeling all feelings, including fear, and not controlling them."

There is a very strange paradox about control that you learn when you get into spiritual work, whether it is through 12 Step programs, Course in Miracles, or a large amount of books and tapes on spirituality from authors like Melody Beattie to Wayne Dyer to Deepak Chopra. The paradox is this: When you let go of control and stop trying to figure it out, you get control. Isn't that strange? I found it unbelievable, but I tried it and it works every time.

One Wednesday night I was sitting in a 12-step meeting. In this particular meeting there was an elderly lady sitting in the corner knitting. She never spoke; she just listened. She looked a little like Aunt Bea from Mayberry who was a sweet, kind elderly lady, knitting in the corner of the room. She sat in the same chair in the same place every meeting, every week. That night I was talking about how bad my day had been. I was filled with anxiety, rituals and obsessions. I was exhausted from it all, and mad, frustrated, and damn angry! The elderly lady put up her hand for the first time in months. She was chosen to speak.

What came out of Aunt Bea's mouth was the most profound thing I had ever heard. She quietly said, "You know, you can start your day anytime you want." The room went quiet, very quiet, for a few moments. Then, my thoughts started to judge her statement, as I had been judging her silence for months. "How can you start your day anytime you want?" I didn't understand. I asked myself, "If I have an anxious day from 7 in the morning until 11 at night and I go to bed at 12 midnight, should I start my day between 11pm and 12 midnight?!" She quietly expressed, "Exactly," and then went back to knitting.

Aunt Bea wasn't Aunt Bea anymore. She was my Guru!

That was the day I started to understand gratitude. I had a horrible day but I could make the conscious decision to start the day over no matter what time it was, and be grateful to the Universe or God that I had an hour of a good day. I could then build on that gratitude. Maybe next time I would have two or three hours, just because I turned my attitude into gratitude. Start my day over at any given moment – what a concept! Rebuild my spirit at any given moment - what a gift! Take back my power and decide to feel the feelings of anxiety and let them pass, at any given moment.

Adding Spirituality, in all its many forms, to my treatment and recovery from Obsessive Compulsive Disorder has changed my life completely. I believe that it is the missing treatment modality that many of us need. It has given me life tools to work with. I wish I had a Spiritual Compassion class in the 3rd grade. For the majority of us, we were never taught spirituality without religion attached to it. Relearning how to look at my life from the inside out has been the most powerful medicine I have experienced.

On my road to recovery, I continue treatment through CBT, ERP, medicine, 12 Step programs, spiritual books and tapes, and lecturing on OCD recovery. You teach what you need to learn! All have helped me get my life back, but the spiritual component has been the strongest. At first spirituality seemed New Age, but it's actually Old Age, based on philosophies centuries old, and now made understandable for us slow learners. Belief was one of the strongest dynamics to change my biology. My heart is now open to all the possibilities of life.

My favorite spiritual saying is, "When the student is ready, the teacher will appear." When I became willing to heal, all new spiritual concepts arrived, and guess what? I started to get better.

Spirituality – who knew?

Finding My Place

By Leigh Katsos

Leigh Katsos is a psychology graduate student who has just set up a Midlands OCD Support Group. Beginning on April 1st, this group will take place at 5:30pm on the first Thursday of every month at Palmetto Health Behavioral Care, 11 Medical Park Road, Columbia, SC. She has also started an online support group, which anyone can visit, at ***http://health.groups.yahoo.com/group/midlandsocd****.*

Having OCD and being a psychology graduate student, I think I have a different perspective on OCD than many other individuals. But trying to find help for myself and trying to figure out how I can help others have not been easy tasks. I have received cognitive-behavioral therapy, have been hypnotized, have talked to many OCD professionals, and have done a great deal of research on the subject. I would like to help others with OCD through a support group, which I have just set up, but it was easier said than done and was more difficult than one would think. With no clear OCD-specific support groups or OCD therapists in my area of South Carolina, I have even more motivation to try to help those in need who may not even know that they have OCD, don't understand what they are experiencing, don't have a name for it, and don't have a face to associate with this debilitating disorder. I want to be that face, that voice.

If you are familiar with OCD, you know it is irrational but that it still tends to take over your thinking. Though cognitive-behavioral therapy (CBT) does work to a certain point, in my experience there was still a "hump" that I could not get over. In the course of my research, I found some things that have been really helpful for me that I would like to share here as a first step in helping those around me.

I have learned that it is useful to give OCD a name; this helps you see OCD as something that is separate from you, because the OCD is not you. It's also helpful to challenge your OCD by saying things like, "You aren't going to get me this time; I am not going to give in." This can be done with some obsessions in order to resist acting on them through compulsions, although anyone with OCD knows that this is not possible with everything. There is always that one thing that you just can't expose yourself to. However, by practicing the little things first and exposing yourself to your fears little by little, those baby steps will turn into miles and miles of accomplishments, some new freedom, and relief from those terrible thoughts that you just wish would go away. There is hope. Just like recovering from alcoholism, you have to make that decision every day of whether or not you are going to act on those obsessions through compulsions. It is how we react to our thoughts and to our compulsions that will get us somewhere. Anyone with OCD knows that is way easier said than done, but knowledge and understanding is very powerful and CBT can be very helpful too.

I have also found that the four steps outlined in Dr. Jeffrey Schwartz's book *Brain Lock* are very helpful. Although this book is over 20 years old, I have tried his four steps and they have worked many times for me. I know that I have a long way to go, but boy, have I come a long way! In his book, he talks about the fact that OCD is a medical condition, and that fMRIs have validated that there is a part in the brain that causes OCD symptoms. Yes, medication can help; however, with his steps, he talks about how you can "unlock" your brain so it is not "stuck" anymore. According to Schwartz, this creates new passageways in the brain for freedom from

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FROM THE FRONT LINES

(Finding My Place, continued)

obsessions and compulsions. I really think it is helpful how he says that when you are having an obsession, you should call it what it is. Tell yourself, "I am having an obsession right now." If you are performing a ritual or compulsion, tell yourself, "This is a compulsion." He also explains the medical side of the brain, and that you are not OCD, but that you have OCD. It is not you, it is not your fault, and it is nothing to be ashamed about. It doesn't define you. I think this is truly an important lesson to understand and remember. He also has a "15-minute" rule that is incredibly helpful with exposure and "unlocking" the brain without medication. Personally, I am not against medication for OCD. If it is needed, it should be used. Would you avoid taking medication for diabetes or high blood pressure? Of course not! OCD is the same thing - it is biological. Sometimes individuals need medication in order to take the steps needed in therapy to get better. I don't think medication is the total answer, but it can help with the process. Every little bit of help is needed when dealing with this disorder. Feeling as if you are a prisoner in your own body is not a good feeling at all. I have also found that Dr. Craig April, one of the therapists on A & E's show "Obsessed," has a wonderful website, as well as Jeff Bell, a spokesperson for the International OCD Foundation and author on the subject of OCD.

In my journey, I am trying to help those in need and help myself as well. I don't want people with OCD to feel that they are alone, that they are crazy, or don't understand what is going on, and most importantly, I don't want anyone to feel like they have nowhere to turn for answers. There are answers out there, there is hope, and there are many faces and voices to this disorder. Sometimes it is hard to avoid feeling like you are a prisoner in your own body. I think it is important to express your feelings with a therapist, take prescribed medication if needed, have a good support system, and to join a support group where individuals *know* exactly how you feel.

YOUTH CORNER

Castle

By Sydney (age 11)

In a way this experience is like you're in a castle,
Trying to break free in one big hassle.

You're trapped behind guards and are tucked out of sight
With only your courage and brain to fight.

And there's a lot to do to get free from that place –
Many problems to solve and obstacles to face.

And though you have clues to help guide you through,
A lot of these tasks are only for you.

You must little by little journey to the end,
Over moats and through bars with only yourself as a friend.

You must break through the walls and set yourself free
Because life is no fun when it's led by OCD.

And once you are away from the misery and taunt
You realize that life can be whatever you want.

THE THERAPY COMMUNITY

Have we forgotten the children who have a parent with OCD?: Accommodation and early intervention

Jennifer Jencks, LICSW and Barbara Van Noppen, PhD

Jennifer Jencks, LICSW, is a private practice clinician who has been specializing in the treatment of OCD in children and adolescents utilizing cognitive behavioral therapy for the past 12 years in Providence, RI. She received her MSW from the Smith College School for Social Work, where she is currently a doctoral student. She plans to do her dissertation research on the impact of parental OCD on their children, and she hopes to contribute to the efforts being made to improve interventions with families impacted by OCD.

Barbara Van Noppen, PhD, is an Associate Professor of Clinical Psychiatry and Associate Chair of Education at the Keck School of Medicine, Department of Psychiatry at the University of Southern California (USC). Dr. Van Noppen is internationally known for her development of a Multifamily Behavioral Treatment (MFBT) for OCD and her inclusion of family members in CBT. She has published numerous journal articles and book chapters on this topic. Currently, Dr. Van Noppen is the Co-Director (with Dr. Michele Pato) of the OCD Treatment and Research Program at Keck School of Medicine, USC. Dr. Van Noppen also teaches and supervises psychiatric residents in the use of CBT for a variety of psychiatric conditions.

Understanding the impact of parental mental health issues on children is a priority today. Research on child development has informed us about the kind of environment and parenting styles children need to develop in the healthiest possible manner. There are numerous articles written to report clinical and research findings about the impact of mental illness on parenting behaviors (see Mann and Gregoire, 2000). In particular, the interaction between multiple factors influences the relationship between parents' psychiatric disorders and children's development; it is a complex picture. To date, little is known about the effects of parental OCD and what happens to the offspring. One study reported the finding that children with a parent with OCD are more likely than those without a parent with OCD to have social, emotional and behavioral disorders (Black, Gaffney, Schlosser and Gabel, 2003). Yet, the good news is that this is not so for all children. Why is this not discussed more in the literature given the prevalence of OCD? What are the risk factors for certain children? How could we offer earlier and better intervention for those families in need?

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THE THERAPY COMMUNITY

(Have We Forgotten, continued)

Obsessive Compulsive Disorder affects 1 in 50 adults, making it one of the most important disorders to research to gain understanding of how its symptoms impact these adults' children. The typical symptoms associated with OCD include intrusive, unwanted thoughts, ideas, or images that evoke anxiety (obsessions); and behavioral or mental rituals performed to neutralize the anxiety (compulsions). When the obsessions and compulsions occur, they can disrupt the normal social and productive functioning of an adult. In this way, OCD impacts entire families because, just by the nature of the disorder, OCD symptoms invade the lives of others, not just the person with the diagnosis.

Accommodation is an intuitive way in which family members try to provide support to the person with OCD, but inadvertently this response reinforces the fears that underlie rituals. Accommodation can be defined as readiness to assist or appease others. In terms of OCD, Waters and Barrett (2000) identify the family context as a potential risk factor in the development and maintenance of the disorder. Storch et al. (2007) have published extensively about pediatric OCD and the role of family accommodation with regard to functional impairment and OCD symptom severity. With regard to adults, Van Noppen and Steketee (2009) identified family accommodation as the largest contributor to predicting OCD symptom severity in a series of path analyses. Despite what we know about how parents, spouses and other family members accommodate OCD, there is almost no discussion of what happens for children trying to cope with OCD demands for a parent. Our aim is to get the dialogue going, to understand what is happening, and to develop effective family interventions.

The Family Accommodation Scale (FAS-IR, Calvocoressi et al., 1999) is a 13- item clinician-administered measure of the extent to which family members accommodate OCD symptoms in specific ways. The original scale was designed to assess the extent to which adults accommodate a loved one's OCD by avoiding certain triggers, participating in rituals, providing excessive reassurance, and modifying personal and family routines. We have recently revised this measure so that it can be used to assess the extent to which children accommodate a parent's OCD symptoms. We will begin to use this measure to identify children and families that need interventions to decrease accommodation and to improve parenting practices which, if left uncorrected, may have a negative impact on a child's development.

Children can accommodate a parent's OCD symptoms in a variety of ways. The following is a series of clinical vignettes, each of which describes a different type of accommodation:

1) **Children may offer reassurance to their parents in order to diminish the anxiety they have regarding their obsessions.**

   "Both of my parents are "germaphobes." My Dad is afraid of the flu, and my mom is afraid of dirt. They are always sitting us kids down and lecturing us about washing our hands. As soon as we get home from school my mom leads us to the bathroom, and I'm pretty sure she sprays Lysol on our school stuff and shoes. Mom expects us to use hand sanitizer at school during the day, too. When I get home that's the first thing she asks - not' 'How was your day?' but, 'Did you use your hand sanitizer?' Now that I'm smarter, I just tell her 'yes' no matter what."

2) **Children may avoid doing or saying things that could trigger a parent's rituals.**

   "My mother was always afraid we would drown. Whenever we went near water, a pool, the ocean, or whatever, she would make us wear a life preserver or she'd hold our hands tightly. She also had words she would say under her breath. Eventually the other kids and I grew to not like swimming, and turned down friends' invitations to the beach. It was just easier."

3) **Children may participate in a parent's rituals or complete rituals on his or her behalf.**

   "It used to take my Dad so long to check the windows and doors in the morning when we were trying to go to school that I just offered to do it for him one day. He was relieved, and next thing I knew I was doing it every day. It was a pain, but at least I got to school on time."

4) **Children may help a parent avoid triggering stimuli.**

"My mother used to bring me into the bathroom with her in public places. Usually she avoided going, but if she needed to she would ask me to clean the toilet seat with a special spray she carried in her purse, and wipe down the door handles. I didn't like doing it, but if I refused she would get really upset."

5) **Children may make decisions for parents to avoid a parent's anxiety of not knowing the right choice.**

"In restaurants, my step-dad would take so long trying to decide what to eat. He would ask everyone what he should have, and sit staring at the menu for a long time. The waitresses would get impatient. One day my brother just ordered for him, and he said that dinner was the best one he ever had. My brother was proud that he helped, and then started making food choices for him more often."

6) **Children may modify their schedules or responsibilities to accommodate their parent's OCD.**

"I clean the bathrooms at home now because my mom just can't do it. She washes her hands over and over when she even stands in the bathroom, never mind touches anything."

7) **Children may complete household tasks for their parent with OCD.**

"My Dad fears trash day. My Mom says he has to take out the garbage, and you can tell by the look on his face he is really afraid. They yell sometimes, and if my Dad can't do it my Mom ends up taking it out. She stomps her feet and mumbles angry things under her breath. I feel really bad sometimes, and if I get home early enough from school I try to take it out before any of that happens."

Some research suggests that children of parents with OCD may be at higher risk of having anxiety, OCD or OCD-like disorders, or behavioral disturbances due to a genetic-environment interaction. That is, the vulnerability to develop OCD is likely heritable, yet not all kids with such parents express OCD. Thus, there must be other factors that affect an individual's biology. Further research has revealed the resiliency that many children demonstrate when raised under adversity. There is much interest in understanding what promotes resilience, which is a process that guides people to "bounce back" from stressful situations. (Dyer and McGuinness, 1996). If we could better define protective factors that reduce the likelihood of children exposed to extreme conditions due to the demands of OCD and develop interventions to assist families with these difficult circumstances, then we would certainly make public health strides.

Interventions aimed at decreasing children's accommodating behaviors will help both the parent and the child. The parent will be better able to treat their OCD symptoms if they are not being accommodated by the family, and the children will be protected from involvement with the OCD and any disruption it may cause in their day to day life and overall development. The following is a list of interventions which could be offered to support families with a parent diagnosed with OCD:

1) **Parenting education and support.** Information on effective parenting practices and why it is important to keep children uninvolved in OCD rituals will help to decrease the impact of OCD symptoms on the child and foster a healthier relationship between the parent and child. Ongoing support, in the form

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of counseling or support groups, will ensure that parents are able to consistently employ effective strategies and not revert back to engaging their children in their rituals.

2) **Psychoeducation.** Educating children about OCD and ways to support a parent in treatment would offer children a way to help their parents in an age-appropriate manner. Children will benefit from a better understanding of a parent's behavior and how they can help by learning what they can say or do. With this information they will be less vulnerable to becoming engaged in OCD rituals and will feel empowered that they are part of the helping process.

3) **Multi-family Intervention.** Multi-family behavior therapy (MFBT) can be utilized to involve whole families in the treatment of OCD and in a group format. Families would receive support from each other, encouragement to stay in treatment and perform exposure and response prevention exercises effectively, as well as ideas regarding how to minimize the impact of OCD on overall family functioning.

4) **Creating or expanding a family's support network.** Families impacted by OCD benefit from the support of a well-informed and caring support network. Working with families to develop this network and use it to get through challenging times will also help to prevent children from participating in their parent's OCD rituals.

5) **Development of coping skills.** Children, in general, are eager to learn and employ new ways to help themselves feel better. The introduction and reinforcement of coping skills will provide them with techniques and strategies they can use when they are experiencing anxiety, depression, or any kind of life stress (including any feelings brought on by living with a parent with OCD). The earlier these skills are introduced, the more likely the child is to embrace them and utilize them during challenging times.

In conclusion, greater understanding of the impact of parents' OCD on their children's development and mental health outcomes is necessary so that effective interventions can be developed and utilized. Further research on this topic, in conjunction with the research on resiliency factors, are imperative so that we can anticipate which youth are at risk and implement appropriate services and supports. With OCD impacting one out of every fifty adults, effective recognition and intervention practices could have a profound impact on the next generation.

We would like to encourage parents with OCD who plan to attend the 17th Annual International OCD Foundation Conference in Washington, DC this July to bring along their children who are not diagnosed with OCD, as well as their children with OCD. We plan to offer a workshop and support group for them during the conference, and hope to learn from them how OCD impacts their functioning as well as their family's functioning.

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OCD Insights from Both Sides of the Couch

By John B.

John B. is also the anonymous author of The Boy Who Finally Stopped Washing, the companion book to the bestseller The Boy Who Couldn't Stop Washing by Judith Rapoport, MD. John's book is unique because it is the only one to comprehensively examine OCD from two perspectives; he is an OCD recovering sufferer and an OCD therapist. His book is available on ***amazon.com*** *and* ***barnesandnoble.com****.*

INTRODUCTION

I am an OCD psychotherapist of over ten years and also a recovering sufferer of almost thirty years. As an individual who has lived both perspectives, I am going to discuss my insights about OCD for therapists so that they might increase positive treatment outcomes and become more empathic to their clients' woes. Conversely, I inform sufferers how to maximize results in therapy and encourage those not in treatment to seek good care. Let me emphatically state that I do not have all the answers. However, I do believe that my life's journey, which also includes a stint as a support group facilitator for several years and a psychotherapy client for twenty-eight years with several different therapists, has equipped me with a wide range of experiences that will be helpful to therapists and sufferers alike.

CAUTION

The following is not new, but it absolutely bears repeating: Exposure and Response Prevention (ERP) therapy is the lone modality, other than pharmacotherapy with selective serotonin reuptake inhibitors (SSRIs), that is scientifically proven to significantly reduce OCD symptoms. Some individuals combine behavioral treatment with medication to enhance therapeutic effects. I speak exclusively about ERP therapy in this article. Be wary of any other form of OCD "treatment." Therapists need to use ERP to specifically target and reduce OCD symptoms. I cannot stress this enough. Therapists that are not utilizing ERP are not treating OCD. Obtaining an experienced ERP therapist is the most important thing for any sufferer. ERP experts include behavior therapists and cognitive-behavior therapists. As I've experienced, divergent therapies might be beneficial for other disorders and problems of living. I almost ran off the road when I heard on National Public Radio that less than fifty percent of OCD "therapists" use ERP -- evidence-based treatment that has well-established efficacy for at least twenty-five years. Relaxation – used by more therapists than ERP -- is not a treatment for OCD. (In Tourettic-OCD, a discomfort- rather than a fear-based subset, relaxation can be therapeutic.)

A myth that needs debunking is that ERP treatment for OCD generates excessive anxiety and consequently is too daunting for some people. I've heard mental health professionals question a client's ability to cope with ERP. At times, other healthcare practitioners are astounded to learn that some sufferers don't require medication and can still beat OCD. As a recovering sufferer and therapist, I'm offended by this distrust in OCD sufferers. The truth is that anybody can do ERP. The human body is hardwired so that the parasympathetic nervous system calms us. Of course, there are people who tolerate discomfort better than others. Characterological and family system issues necessitate more therapy, but with a seasoned and creative therapist, treatment can help any sufferer. It usually helps very significantly. Gradual exposures performed in a systematic manner help; that is what thirty years of peer-reviewed controlled research demonstrates. Another falsehood is that people that obsess more and do fewer overt rituals are more difficult to treat. As one of those individuals, I declare, "Baloney."

ERP TREATMENT

A prerequisite for ERP is that sufferers change their approach to managing anxiety. ERP asks you to confront and even search for opportunities to induce anxiety. Instead of defending against the discomfort, play offense. The best defense is a good offense. Attack anxiety head-on and you will always experience that its power

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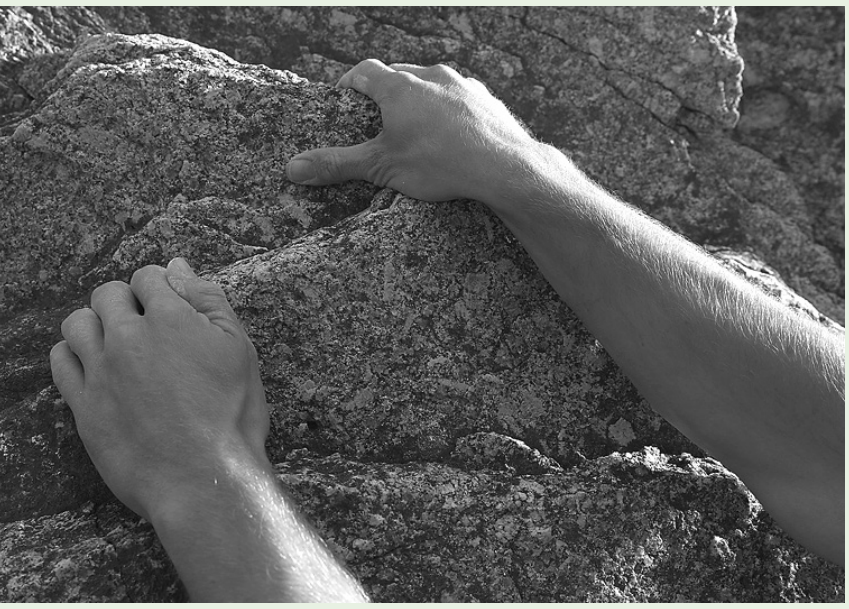
(Insights from Both Sides, continued)

diminishes. Once exposed to a stimulus, your levels of anticipated and actual anxiety will seem exaggerated. This is a sign that OCD is on the run. Doing rituals and avoiding anxiety-provoking situations have not worked except to lead you to treatment. Try a different course since what you have tried has led you astray.

During the first or assessment phase of ERP treatment, I normalize and universalize the client's symptoms (e.g. "OCD is too much of a good thing," or "Everyone has irrational fears," and "No one wants something terrible to happen to a loved one, etc.); however, I make sure to allow the sufferer some room for being an individual. A person needs to know, despite having OCD, that he or she is not solely regarded as a special person, but also as a unique sufferer with a distinct constellation of obsessions and compulsions. Sufferers need to experience that the therapist respects the pain and discomfort that has humbled him or her to entrust the practitioner for assistance. A sufferer who has contamination fears and washes his or her hands a certain prescribed way doesn't want to be lumped together with all washers. Yes, there are millions more "washers," yet each one has a different strain of OCD and is a separate individual. It's a big disappointment when a therapist views you through an oversimplified lens and concludes that much behavior must be explained by a label. I have frequently been perceived as an anxious person and some of my therapists have believed, or at least speculated, that anxiety was the impetus for most of my behaviors. Nobody is constantly and unremittingly anxious; please do not view me only as anxious but as a whole person with a wide range of feelings. Help me feel more comfortable with discomfort and express emotions that I'm anxious about letting go.

By the end of the assessment phase, a therapist identifies one or more obsessional themes. Be careful that the theme(s) reflect(s) the real, actual fear(s). If it doesn't (they don't), the inaccurate theme(s) is (are) invariably a common reason(s) for ERP to falter. The accurate underlying fear(s) has (have) not been discovered. For instance, a person who has contamination fears that a loved one will become sick and possibly die if he or she is "dirty" when touching the family member might ultimately possess another fear. In this case, assume that the core fear is that the sufferer would not be able to care for him or herself and would become vulnerable to a host of life problems if a family member does get very sick or die. Helpful treatment accounts for the additional information about the fear. A way to get to the core fear is to ask, "What would be the worst thing that could happen if...?" Exposures would be designed differently to focus on the newfound fear. ERP will now have a great probability of effecting change in this person's life.



The worst thing the therapist can do during treatment is to imply that he or she doesn't have confidence in the client to face fear. Sometimes by rigidly sticking to a predetermined SUDS (subjective units of distress) hierarchy and not having flexibility with day to day changes in a client's anxiety levels, therapists unwittingly send that message. I listen to the client's modifications unless a pattern of avoidant behaviors emerges. I use the higher rating that the client tells me during the session, not what was reported three weeks ago. On the other hand, I do not hold sufferers back from taking on an exposure unless their judgment is poor, awareness and attunement to their emotions are poor, experience shows it doesn't work, or the client is manic or hypomanic (highly activated) during ERP and is unrealistic about what he or she is prepared to face. Emphasize doing direct, prolonged, and repeated exposures. Response-prevention (RP) is a very important component of ERP treatment; however, note that some sufferers do not practice exposures enough, which doesn't allow the client to heighten anxiety enough for ERP to maximize gains.

If apprehension sets in during ERP with a client with whom I have good rapport, I might say to him or her, "Well, you know, if you touch the table, you are living on the edge. I wouldn't do it. Others don't touch it; it must be hazardous to your health. Some people live on the edge jumping out of airplanes. You do by touching tables." Humor, or my weak attempts at it, peels back layers of anxiety, increasing the probability that the person, and not OCD, governs behavior. We both usually chuckle at the absurdity of the fear. There are usually inconsistencies the fear has with other behaviors he or she engages in (e.g. public speaking, rock climbing, etc.). Point out the inconsistencies because the "behavioral dissonance" does not make sense to the client and will help guide him or her toward exposures. I say, "You mean you can do X which I can't do, but you can't or won't do Y, a behavior almost everyone performs." I tell clients that they are in charge of the treatment because I can't force them to behave in any way. But before they know it, they are doing things that they didn't believe they would ever be able to do. I empower them, or grant them permission, to behave how I want them to. Therapists, never take any progress for granted. Confronting your worst fears is extremely uncomfortable. It's incredible that clients, in spite of living and struggling mightily with OCD, change. ERP works better than I imagined it would when I started my practice.

A WORD TO THE WORRIED

Sufferers, tell your therapist everything about your OCD. Your therapist is on your side and knows that OCD, and not you, is responsible for the content and nature of the fears and rituals. You do not have to feel embarrassed, guilty, or anxious. Therapists hear secrets and "hard-to-tell-anyone-things" all the time. Sexual, violent, and blasphemous thoughts are common; I call them the Unholy Trinity of OCD. I didn't tell my therapist some embarrassing information a long time ago and I realized later that he could have helped me much sooner. I could have prevented large amounts of anxiety from burdening me for years. A very apprehensive teenager, I didn't speak to my first therapist for about three or four sessions. As a seasoned OCD therapist, I infrequently hear something completely different than what I have already heard. I tell my clients that it's my job to hear things that are difficult to say and that unlike most people you encounter, I'm someone who understands their condition. It amazes me how much people talk to and place their trust in me. Sadly, I recently found out that I could have helped someone earlier if he or she would have opened up more. You don't have to suffer.

SPECIAL CONSIDERATION

One disadvantage of being a therapist who has experienced OCD is the possibility of identifying too closely with a client. Over-identifying can possibly lead to a deceleration of treatment because the therapist doesn't want to revisit any unresolved issues (and become anxious) and view others as anxiety washes over him or her. I have to be vigilant about my feelings and thoughts in sessions, particularly when a client or his or her OCD reminds me of myself in any clinically significant manner. Fortunately, this happens infrequently, but I know that if I am thinking about me too much during a session, I have to refer the client to someone else because I can't handle the case. This has not occurred.

DUKE OF DOUBT TO HOLINESS OF HOPE

Phenomenologically, OCD does not occur as it indicates in textbooks and workbooks. It is exponentially more complex because obsessions and compulsions happen in life's context. Other fears, sensory inputs, and cognitions might be flooding the brain simultaneously. It is not so simple: to feel the anxiety and not ritualize or avoid the anxiety. Everyday events, both overt and covert, intrude and compete for psychic energy, demand attention, and make feeling anxiety more difficult and doing rituals more appealing. Life appears to run smoother. But don't be tricked by this seductive mirage. Attack, attack, attack. Do not be satisfied with partial success. As a sufferer, you are doing well if you are functioning relatively well and are happy most of the time. Even then, do not be complacent, for OCD tends to worsen if symptoms are not addressed. Life is too short not to use an effective tool. And in spite of life's complexity and intricacies, ERP puts OCD in its crosshairs and gives you the chance to eradicate it. Take the opportunity!

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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 IOCDF. The IOCDF's Institutional Members are all programs that offer more than traditional outpatient therapy for individuals who need higher levels of care. Please see the announcements below for recent program updates and announcements.

CALIFORNIA

Cognitive Behavior Therapy Center for OCD & Anxiety begins to offer guided meditation practice

The Cognitive Behavior Therapy Center for OCD & Anxiety in San Rafael, CA now provides guided meditation practice for patients to develop a state of mind that regulates and heals distressful emotions. With reduced emotional distress, the chance of OCD symptoms returning is reduced and recovery is enhanced. Those who meditate report reductions in many unpleasant feelings like anger, grief, depression, and fearfulness and increased feelings of peacefulness, closeness to others, and being productive, all of which can help to prevent the return of symptoms. For more information about the CBT Center, please visit **www.cbtmarin.com**.

KANSAS

Kansas City Center for Anxiety Treatment (KCCAT)/KU Medical Center Anxiety Research Program adds new staff and services

KCCAT has welcomed Ashley Smith, PhD, to their team approach to treatment. Dr. Smith received her PhD in clinical psychology from the University of Nebraska-Lincoln. Her primary research and interests focus on social anxiety in adolescents and the overlap between OCD and eating disorders, and she has recently developed a brief treatment model targeting early childhood anxiety. She completed an APA-accredited internship at Children's Mercy Hospital and postdoctoral and staff psychologist appointments at the Anxiety Disorders Specialty Clinic at Omaha Children's Hospital. Dr. Smith provides parent education groups and clinical services for anxiety and OCD patients of all ages.

Additionally, a new "team support service" is available to KCCAT patients for assistance in making the most of treatment while helping to control session time and costs. For those who would benefit from extra assistance with ERP/hoarding protocol homework and closer monitoring between clinical sessions, we are pleased to offer this adjunct service at a nominal fee of 50 cents per minute, including no travel-time fees within the greater Kansas City metro area. For more information about KCCAT, please visit **www.kcanxiety.com**.

OCD and the Law/Prisons: Looking for Personal Stories

We know prisons are over-crowded with people who require psychiatric treatment and who are not receiving adequate care. There is very little information on this topic except for some personal accounts on the internet of people with OCD being arrested for "disturbing the peace" or other "odd/threatening" behaviors because it was not understood that their actions were symptoms of OCD. Thus, people with OCD are likely being arrested without their disorder being properly diagnosed and treated.

In an effort to understand more about the prevalence, incidence and treatment of people with OCD who become incarcerated, we are collecting anecdotal reports. If you have a story to share, please email it to Dr. Graham Mitchell (**gmitch1978@gmail.com**) and Dr. Barbara Van Noppen (**vannoppe@usc.edu**). Thanks for your help!

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.** Please indicate in your email if you wish to remain anonymous if your submission is chosen for publication.

RESEARCH NEWS

What is Acceptance and Commitment Therapy, What is its Effectiveness, and Should I Look Into It?

Michael Twohig, Ph.D.

Michael P. Twohig, Ph.D. is a licensed clinical psychologist in Utah and an assistant professor at Utah State University. He received his Ph.D. from the University of Nevada, Reno, and completed his clinical internship in the CBT track at the University of British Columbia. His research spans a variety of areas including the treatment of obsessive compulsive disorder and OC-spectrum disorders, substance use, mechanisms of action, and multicultural issues. He has published over 50 scholarly works including two books: An ACT-Enhanced Behavior Therapy Approach to the Treatment of Trichotillomania (with Woods) and ACT Verbatim for Depression and Anxiety (with Hayes). His research is funded through multiple sources, including the NIMH.

What is Acceptance and Commitment Therapy for OCD?
Acceptance and Commitment Therapy (ACT, said as one word and not spelled out) is a form of Cognitive Behavioral Therapy (CBT) in the same way that Exposure and Ritual Prevention (ERP), Cognitive Therapy, and Dialectical Behavior Therapy are forms of CBT. All of these interventions share certain therapeutic or philosophical elements that put them under the CBT umbrella rather than other umbrellas (such as psychoanalysis or humanistic psychology, for example). Some of the defining elements of CBT interventions, including ACT, involve:

- Viewing behaviors as shapeable or changeable through environmental manipulations, rather than seeing behaviors as solely biological or neurological in nature, and thus responsive to psychotherapy;
- Focusing on the way the client interacts or responds to events (including thoughts and feelings) in his or her life rather than intrapsychic events, developmental milestones, or personality characteristics; and
- Testing the effectiveness of its interventions as well as the processes through which they work.

There are some places, though, where ACT may be different than more commonly practiced forms of CBT. The most commonly used and supported forms of CBT for OCD are ERP and ERP with cognitive challenging (the term ERP will be used to cover both in this article). The ultimate goal of ERP is greater functioning of the client, and it appears that most ERP models focus on reducing obsessions and associated anxiety so that greater functioning can be achieved. Subjective Units of Discomfort (SUDS) scores are collected throughout therapy. Measures of OCD severity place equal emphasis on the frequency and severity of obsessions and compulsions. This focus is also evident in ERP where equal time is spent focusing on reducing obsessions and compulsions. ACT is purported to be different than ERP in that it focuses less on the reduction of inner experiences (such as obsessions) and more on altering the way they are experienced. ACT sees inner experiences, such as obsessions and anxiety, as part of our lives. Obsessions and anxiety are not inherently bad events, but they are treated that way by most of society. ACT focuses on finding a way to allow obsessions and anxiety to come and go without interfering with the way one lives his or her life. Thus, greater functioning can be achieved without a change in severity or frequency of obsessions or anxiety. This is a position that is shared with other forms of CBT, but possibly emphasized to a lesser extent.

Individuals diagnosed with OCD or therapists who work with these clients may have a "negative" reaction to the idea of living with obsessions and anxiety. If you experienced the same reaction when you read the last paragraph, just notice that reaction and answer these questions:

- Has attempting to control or regulate obsessions and anxiety worked over the long-term?
- Has this lessened the obsessions and anxiety in a meaningful way?
- Finally, has your life become more open and fulfilling as a result of these attempts to regulate obsessions and anxiety?

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(ACT, continued)

If you answered "yes" to all of these questions, then keep doing what you are doing. Follow your experience; it is more honest than your mind. If you answered "no" and what you are doing is not lessening these obsessions, your life feels more restricted, and you are getting further from where you want to be, then some of the concepts from ACT might be useful for you.

One of the central concepts of ACT is that there is a big difference between what one thinks or feels and what one does. ACT is based on the model that the things people think and feel, or the bodily sensations that one has, are not under that person's control in any meaningful way. But, what a person *does* while thinking, feeling, or experiencing a sensation *is* under his or her control. To illustrate this, answer these two questions: 1) For $1,000, could you prevent yourself from having an obsession over the next 24 hours, and 2) For $1,000, could you stop yourself from engaging in your compulsion(s) over the next 24 hours? Most people would probably experience their obsession, but would find a way to avoid engaging in the compulsion(s). This exercise illustrates that while obsessions and compulsions often occur together, they are not technically tied to each other. We can experience obsessions and not engage in compulsions. Also, compulsions are much easier to control than obsessions. This is partially why ACT focuses on what one does and less so on what one thinks or feels.

People generally work to control obsessions and related anxiety because they are experienced as dangerous, threatening, uncomfortable, or some other "negative" evaluation. But there is another aspect to obsessions and anxiety that is overlooked—they are just thoughts in one's head and are feelings that one experiences. Humans are constantly thinking and feeling, but most of the time we do not grab on to any of these events. ACT aims to teach us ways to experience obsessions and anxiety as just thoughts and feelings that we may or may not respond to. When obsessions and anxiety are experienced in this way, it is much easier to respond flexibly to these experiences.

The focus of ACT for OCD is to help clients get to a place where they can openly experience thoughts, feelings, or bodily sensations, not be overly impacted by them, and continue to move in directions in life that are meaningful. The benefit of this approach is that a reduction in obsessions and anxiety is not necessary to begin changing one's actions. From the ACT point of view, the problem with OCD is not that obsessions and compulsions occur, but that every time an obsession occurs the compulsion follows. ACT aims to teach the flexibility to engage in an unlimited number of responses when the obsession is there. There is a way to keep working, play with the kids, eat dinner, talk with a friend, or engage in whatever the chosen activity is *while experiencing the obsession*. This involves experiencing obsessions for what they are (just words in one's head, and words are not dangerous), making room for them as just another experience, and moving forward in directions that are meaningful while the obsessions are there. If this is practiced enough, eventually it becomes easy, and the precise thought or feeling that shows up does not interfere with one's actions. There is a way to experience obsessions AND do what is important in life.

Is ACT for OCD Effective?

The effectiveness of ACT for OCD has recently been tested in a large trial funded through the National Institute of Mental Health (Twohig et al., 2010). In this study, eight one-hour sessions of ACT for OCD with no in-session ERP were compared to Progressive Muscle Relaxation (PMR) with assessments taken at pre-treatment, post-treatment, and at a three month follow-up. PMR was viewed as a control condition in this experiment, so most of this review will focus on the results for the ACT condition. In this study, 79 adults (41 in the ACT condition) diagnosed with OCD were treated. All types of OCD were included in this study (hoarding, primary obsessions, checking, cleaning, etc.) and there were very few exclusion criteria, thus hopefully representing a fairly realistic sample of participants. The treatment was found to be highly acceptable. Only 12% of the sample in the ACT condition refused or dropped out, which is quite low for OCD treatment trials. All participants in the ACT condition rated the treatment as a 4 or greater on a 5 point scale, with 5 being the most positive score. These findings are meaningful because low drop-out and high acceptability are difficult to achieve in the treatment of OCD. ACT was more effective than PMR in the treatment of OCD, with clinically significant change in OCD severity occurring more in the ACT condition than PMR using multiple criteria and including all participants, even those who dropped out (clinical response rates: ACT post=46-56% and ACT follow-up 46-66% vs. PMR

post=13%-18% and PMR follow-up 16-18%). ACT also had a greater effect on depression and resulted in greater improvements in quality of life than PMR. These findings are in addition to previous smaller studies showing that ACT's effectiveness for OCD (Twohig, Hayes, Mausda, 2006a), skin picking (Twohig, Hayes, Mausda, 2006a), and ACT plus habit reversal in the treatment of trichotillomania (hair pulling) (Twohig & Woods, 2004; Woods, Wetterneck, & Flessner, 2006).

Should I Look into ACT for OCD?

ACT for OCD is a newer treatment and the research is quite limited compared to the work that has been done on ERP and ERP with cognitive procedures (often referred to as CBT). ERP with or without cognitive procedures should be the first line of treatment someone seeks out. ACT procedures integrated into exposure therapy may be useful for people who are struggling with ERP. Finally, if exposure procedures are not useful, ACT may be considered as an alternative treatment. ACT is especially appropriate for people who have been unsuccessful at regulating or controlling obsessions and anxiety—especially after full trials of other treatments. It is also well-suited for people who are very tied into their obsessions and feel like they have very little control over their reactions to obsessions. There are a growing number of therapists who are trained in the use of ACT for OCD. If someone is interested in seeking out one of these therapists, refer to the "Find an ACT Therapist" link at **www.contextualpsychology.org**.

References

Twohig, M. P., Hayes, S. C., & Masuda, A. (2006a). Increasing willingness to experience obsessions: Acceptance and commitment therapy as a treatment for obsessive-compulsive disorder. Behavior Therapy, *37, 3-13.*

Twohig, M. P., Hayes, S. C., & Masuda, A. (2006b). A preliminary investigation of acceptance and commitment therapy as a treatment for chronic skin picking. Behaviour Research and Therapy, *44, 1513-1522.*

Twohig, M. P., Hayes, S. C., Plumb, J. C., Pruitt, L. D., Collins, A. B., Hazlett-Stevens, H. & Woidneck, M. R., (2010). A randomized clinical trial of acceptance and commitment therapy vs. progressive relaxation training for obsessive compulsive disorder. Under Review.

Twohig, M. P., & Woods, D. W. (2004). A preliminary investigation of acceptance and commitment therapy and habit reversal as a treatment of trichotillomania. Behavior Therapy, *35, 803-820.*

Woods, D. W., Wetterneck, C. T., & Flessner, C. A. (2006). A controlled evaluation of acceptance and commitment therapy plus habit reversal for trichotillomania. Behaviour Research and Therapy, *44, 639-656.*

Research Participants Sought

ILLINOIS

Paliperidone Study for Adults with OCD

Have you been diagnosed with a problem called Obsessive-Compulsive Disorder (OCD) and not responded to past medication or counseling treatment? If so, you may be eligible for a study examining if adding a medication called Paliperidone helps reduce your OCD symptoms. The Department of Psychiatry at IU School of Medicine is conducting this study.

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 seven psychiatric evaluations that take place. Study medication and the evaluations will be provided at no charge. Financial compensation is available for qualified participants. Risks associated with the study will be disclosed prior to study participation. For more information call (317) 948-0038.

MASSACHUSETTS

Appearance Concerns Treatment Research Study

- Do you dislike the way any part(s) of your body (for example, your skin, hair, nose, eyes) look?
- Do you think about your appearance for more than one hour per day?
- Do you worry that your muscles are not big enough, or do you spend a lot of time lifting weights to enhance your muscles?
- Do you engage in any behaviors intended to check on, hide, or fix your appearance (for example, mirror checking, comparing yourself to others, excessive grooming behaviors)?
- Or do you avoid any places, people or activities because of your appearance concerns (for example, do you avoid bright lights, mirrors, dating, or parties)?
- Do your appearance-related thoughts or behaviors cause you a lot of anxiety, sadness, or shame?
- Do you have problems with your work, school, family, or friends because of your appearance concerns?

If you answered any of these questions with 'yes', you might be eligible to participate in a study at the Massachusetts General Hospital (MGH). If you qualify, you will receive the following:

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RESEARCH NEWS

(Research Participants Sought, continued)

- Diagnostic Evaluation at no cost
- Medication Treatment at no cost

You will also be asked to fill out some questionnaires assessing body image symptoms, anxiety and mood. The treatment will be at no cost for you.

If you are interested in participating or would like to get further information, please call the Body Dysmorphic Disorder Clinic at 1-877-4MGH-BDD at the Massachusetts General Hospital (MGH), or email **BDD@partners.org**. Please visit our website at **www.mghocd.org/BDD**.

NEW YORK

Investigating How OCD Works in the Brain

Would you be interested in helping us learn more about how OCD works in the brain? The OCD Research Clinic at the Columbia University Medical Center is conducting studies using techniques such as functional magnetic resonance imaging (fMRI), measurement of the startle response, and manual and computer-based tests to learn more about the neurobiology of OCD. If you are over 18 and have OCD, you might be eligible for one or more of our current studies. For each study you choose to participate in, you will be compensated for your time. To schedule a confidential screening, contact: Jose Hernandez #212-543-5367 or Rena Staub #212-543-5380, or visit our website at **http://www.columbia-ocd.org**.

NEW YORK and PENNSYLVANIA

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**.

PENNSYLVANIA

Kids with Obsessive Compulsive Disorder (OCD)

Does your little kid have to have things "just right?" Does he have to keep doing something over and over again? Does she have thoughts that constantly bother her? The Child and Adolescent OCD, Tic, Trich and Anxiety Group (COTTAGe) is looking for kids ages 5-8 with OCD to participate in a research study at the University of Pennsylvania. Those eligible receive a full assessment of symptoms and 12 weeks of behavioral therapy at no cost. Call Aubrey Edson at 215-746-3327 if interested or if you're not sure if your child has OCD.

If you would like to advertise your research study in this newsletter or on the IOCDF website, please email **editor@ocfoundation.org** for more information.

FROM THE AFFILIATES

Affiliate Updates

We are pleased to announce the addition of a new IOCDF affiliate in California:

OCD Sacramento Foundation, Inc.
President: Robin Zasio, PsyD, LCSW
P.O. Box 279035
Sacramento, CA 95827

Temporary phone number routed through
The Anxiety Treatment Center of Sacramento:
Phone: (916)366-0647 x4
Fax: (916) 487-4408
Website: **www.ocdsacramento.org**
Email: **info@ocdsacramento.org**

Please see the announcements below for additional affiliate updates.

FLORIDA
OCD Jacksonville
www.ocfjax.org

In January, Jeremy Cox from the Times Union visited one of our support groups to hear the personal stories of those with OCD. His article, "Are Anxiety-Filled Obsessive Rituals Ruining Your Life?" was featured in the Times Union news as well as its sister publication, "H Magazine."

OCD Jacksonville will begin "OCD in the Classroom" presentations on March 24th in Duval and Clay county schools. We will continue to reach out to other counties in our service areas in North and Central Florida as well as our new areas in Southern Georgia. We are pleased to be partnering with schools to increase awareness of OCD in children. Earlier recognition of OCD will hopefully lead to earlier treatment and better outcomes.

We are also in the early stages of partnering with the Veterans Center to widen support given to our military men and women suffering from OCD and anxiety. While we are not sure of specifics as of this printing, we are very honored to be able to serve those who have served.

MASSACHUSETTS
OCD Boston
www.ocfboston.org

New BDD Support Group to Follow Lecture Series
Every month OCD Boston, in conjunction with McLean Hospital, presents a series of preeminent speakers in the field of OCD and related disorders. Each presentation takes place in the De Marneffe Cafeteria Building at McLean Hospital in Belmont, MA.

Obsessive Compulsive & Related Disorders
Les Grodberg Memorial Lecture Series 2009 – 2010
Sponsored by OCD Boston, an Affiliate of the International OCD Foundation

6/1/2010 7-8pm	Room 132 De Marneffe Cafeteria Bldg	Lecture: Medication Q&A	Michael Jenike, MD McLean OCD Institute/ Harvard Medical School

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

A professionally-led support group for parents of individuals with OCD and Related Disorders takes place directly before each monthly lecture. This group will run from 6-7pm in Room 116 of the De Marneffe Cafeteria Building at McLean Hospital. Free babysitting will be provided.

Following each lecture, there are several free self-help groups that are open to the public. The groups will begin at 8pm and run until approximately 9:30pm in rooms 114, 118 and 132 in the De Marneffe Cafeteria Building. The identity of participants

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FROM THE AFFILIATES

(Affiliate Updates, continued)

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.

OCD Boston is pleased to announce the start of a new BDD support group that will take place after each monthly lecture at McLean. This group will run from 8-9pm and will take place in Room 118 in the DeMarneffe Building. For more information about this new support group, please email **Jen_thorne@yahoo.com**.

For more information on support groups, the lecture series, or the OCD Boston affiliate, please contact Denise Egan Stack at (617) 855-2252.

MINNESOTA
OCD Twin Cities
www.ocdtc.org

Golf Fundraiser to benefit OCD Twin Cities
The OCD Twin Cities affiliate is pleased to announce our upcoming fundraising event:

1st Annual Minnesota Bank Alliance Golf Classic
When: 11am on June 16th, 2010
Where: Stone Ridge Golf Club, Stillwater, MN
For more information about this event, or to register, please visit:
www.golfdigestplanner.com/14516-bankalliance

PENNSYLVANIA
OC Foundation of Western PA
www.ocfwpa.org

OC Foundation of Western PA (OCF/WPA) Announces New Support Group, Final 2009-2010 Lecture Series Date, Updated Website, and the Launch of its Facebook Page

To take advantage of the benefits of exercise for people with OCD, every Tuesday at 6pm you can meet with the "OCD and Friends Exercise Support Group." Currently, the group meets Tuesday nights at 6:00 at Caribou Coffee, 2729 E. Carson Street, near the Hot Metal Bridge and South Side Works. Members will run and/or walk on the Three Rivers Heritage Trails according to their fitness level. Plan to move for 45 minutes to allow for warm up, 30 minutes of moderate exercise followed by a cool down. Please view the Events Calendar at **www.ocfwpa.org** to check for an alternate meeting time or location prior to attending. Family, friends and treatment providers are welcome to join the group.

In June the OCF/WPA's 2009/2010 lecture series will wrap up with a 2-hour continuing education seminar on "Recognizing and Treating Compulsive Hoarding." LIFE Pittsburgh is co-sponsoring this event. Due to space limitations, this seminar is only open to licensed mental health professionals. Please contact Elaine Davis, PhD at **ocdirections@verizon.net** for details on this seminar.

Please visit the OCF/WPA's updated website at **www.ocfwpa.org**. The changes have not only made the site more attractive, but will also help people locate the information they need. Most of the original features that people found helpful are still available, but much of the information has been updated. In addition to several other new features, an events calendar has been added so you can easily see when support groups and educational events will take place. Please check it out!

Finally, the OCF/WPA would like to announce that it has a Facebook page. If you have a Facebook account, please visit **http://www.facebook.com/home.php?#!/pages/Obsessive-Compulsive-Foundation-of-Western-Pennsylvania/108186369206615?ref=ts**.