

FROM THE FOUNDATION

OCF Announces 2009 Research Award Recipients

The OCF is committed to finding and promoting effective treatment for everyone with OCD. Research is vital to understanding more about OCD and related disorders and as a way of improving treatment. Since 1994, the OCF has funded over \$2.5 million in research. Research money comes from generous donors within the OCF community and this year a total of \$217,809 was raised. Thank you to all who contributed!

This year the OCF received 50 proposals which were reviewed by the Grant Review Committee led by Sabine Wilhelm, PhD, Vice Chair of the OCF Scientific Advisory Board. Recommendations by this committee were submitted to the OCF Board of Directors who made the final selection. Thank you to all who contributed their time and energy. Please turn to p. 18 to see a list of the winners and a brief description of each study. *(continued on p. 18)*

Excitement Builds for 16th Annual OCF Conference

The date for OCF's 16th Annual Conference (August 7-9, 2009 in Minneapolis, MN) is quickly approaching. Hundreds of attendees have already signed up, but there is still plenty of room for you to take advantage of the only national event dedicated to OCD and OC Spectrum Disorders.

This year's program is shaping up to be one of the OCF's best. We will be offering more than 100 presentations and 12 support groups, many of which will give you the opportunity to participate in hands-on workshops with some of the most well-known names in OCD treatment.

If you have hoarding issues, be sure to bring a box of things with you to Minneapolis. Dr. Gail Steketee and Dr. Randy Frost will help you de-hoard the box on-site during their "Learning to De-Hoard: An Experiential Workshop for People with OCD" session.

Dr. Jonathan Grayson and his team will once again offer their "Virtual Camping Trip." Repeating this experiential workshop for the 9th year, Dr. Grayson and program participants – consumers, family members, and professionals – will go on a field trip throughout Minneapolis in which participants will experience the exhilaration of conquering OCD fears in a group that goes beyond your imagination.

For those attending with family members, Dr. Barbara Van Noppen will lead a hands-on workshop called, "Working Together to Quiet OCD." In this experiential session families will learn how to use *(continued on p. 2)*

IN THIS ISSUE

From the Foundation

Behavior Therapy Institute Announcement 2
President's Message 3

From the Front Lines

My Personal Journey with OCD,
by Nancy Mason..... 4
ocd, by Terry Mullaney 5
"Not Right" OCD and Interactive Storytelling,
by Emily Kelly 6

Organized Chaos: For Teens & Young Adults

A Teen's Life with OCD, by Ray 8

The Therapy Community

Deep Brain Stimulation for Highly
Treatment-Resistant OCD, by
Darin Dougherty, MD, and
Benjamin Greenberg, MD, PhD. 10
The Relationship Between Eating
Disorders and OCD, by
Fugen Neziroglu, PhD..... 12
The Treatment of OCD in Young
Children, by Drs. Golda S. Ginsburg,
Kimberly D. Becker, Marcy Burstein,
and Kelly L. Drake 15
Institutional Member Update 17

Research News

OCF Announces 2009 Research
Award Recipients..... 18
Research Digest, by
Maggie Baudhuin, MLS, and
John Greist, MD..... 20
Research Participants Sought..... 22

From the Affiliates

Affiliate Update 24

FROM THE FOUNDATION

(Annual OCF Conference, continued)

behavioral contracting to reduce the impact of OCD symptoms on personal and family functioning while fostering a supportive environment for ERP.

In addition to these hands-on workshops, recent research findings regarding OCD in children and the genetics of OCD will be presented to the public for the first time. There will also be plenty of advanced OCD information for treatment providers. More than 30 sessions have been approved for both CE and CME units and are available for physicians, nurses, psychologists, social workers, and counselors.

During our Keynote Address featuring Terry Murphy, the author of *Life in Rewind*, OCF will present Dr. Michael Jenike with a Lifetime Achievement Award for his work on behalf of the OCD community. Over his tremendous career, Dr. Jenike has improved the lives of thousands of people affected by OCD, and we are honored to present him with this well-deserved award.

Finally, prior to the Keynote Address, Diane Davey, President of the OCF Board of Directors, will be making an important announcement regarding the OCF. Make sure that you're one of the first to hear the news!

For a complete schedule, information on continuing education for professionals, and to register, please visit: <http://conferences.ocfoundation.org> or call (617) 973-5801. We look forward to seeing you in Minneapolis!



Mark Your Calendar Now for the Third 2009 OCF-Sponsored Behavior Therapy Institute

October 9, 10 & 11, at San Diego State University in San Diego, California

The Behavior Therapy Institute is an In-Depth 3-Day Training Program in
State-of-the-Art Cognitive Behavioral Therapy for OCD

- Experienced OCD Faculty
- CE Credits Available
- Low Registration Fee
- Space is limited to the first 30 registrants!

Faculty

John Piacentini, Ph.D.

Associate Professor, Psychiatry and
Biobehavioral Sciences, University of
California, Los Angeles

C. Alec Pollard, Ph.D.

Director, Anxiety Disorders Center, Saint
Louis Behavioral Medicine Institute,
Professor of Community and Family
Medicine, Saint Louis University

Nader Amir, Ph.D.

Associate Professor, Department
of Psychology
San Diego State University

Sanjaya Saxena, M.D.

Director, UCSD
Obsessive-Compulsive
Disorders Program
Professor, Department of
Psychiatry
University of California,
San Diego

Jeff Szymanski, Ph.D.

Executive Director, Obsessive
Compulsive Foundation,
Clinical Instructor, Harvard Medical School

Gerald Tarlow, Ph.D.

Director, Center for Anxiety Management in
Santa Monica, CA, Clinical Professor, Department
of Psychiatry, University of California, Los Angeles

Barbara Van Noppen, Ph.D.

Assistant Chair of Education, Keck School
of Medicine, Department of Psychiatry,
University of Southern California

For more information regarding the Institute or to view our BTI Handbook and BTI Registration Form: Visit the OC Foundation website at www.ocfoundation.org or contact Michael Spigler at (617) 973-5801 or mospigler@ocfoundation.org

This program is sponsored by the Obsessive Compulsive Foundation (OCF), Inc. This program has been approved by the National Board for Certified Counselors (Provider #SP-1629). Course meets the qualifications for 21 hours of continuing education credit for MFCCs and/or LCSWs as required by the California Board of Behavioral Sciences (Provider #PCE 4422). This program is approved by the National Association of Social Workers (Provider #886509959) for 21 continuing education contact hours. OCF is approved by the American Psychological Association to sponsor continuing education for psychologists. OCF maintains responsibility for this program and its content.

Message from the President



Dr. Michael Jenike, Chair of OCF's Scientific Advisory Board, and Diane Davey, OCF President, at the OCF Open House, April 2009

Dear Friends,

It is almost impossible to believe that the summer is nearly half over and that the Annual Conference is just around the corner. It isn't too late to join us in Minneapolis for what promises to be an exceptional weekend filled with information for consumers, therapists and researchers alike. If you haven't already decided to attend, I hope that you will consider doing so. You can download the conference registration brochure from the OCF website and take a look at the many offerings at the conference this year. We have brought together the best presenters from the field of OCD and OC Spectrum Disorder treatment and research for this year's conference. There will truly be something for everyone!

Personally, I am excited and touched to be able to honor my friend and the Chair of our Scientific Advisory Board, Dr. Michael Jenike, with a Lifetime Achievement Award as part of the conference's Keynote Address this year. After countless years of dedication to the OCF and, more importantly, to the cause of helping people with OCD, this is an award that is most deserved. I hope you will come and help me honor Dr. Jenike.

It gives me enormous pride and pleasure to see the announcement of the 2009 OCF Research Award Recipients in this newsletter. This year we received a record number of grant proposals, and these recipients' projects were rated the very best among those we received. A special thanks to our Scientific Advisory Board's Vice-Chair Dr. Sabine Wilhelm and other members of our Scientific Advisory Board who dedicated many hours reviewing all of these proposals so carefully. As you read the summaries of the funded projects I hope that you, too, will feel a sense of pride about how the OCF community continues to contribute to the most cutting edge research in the hopes of finding better information, treatments, and eventually a cure for OCD.

Finally, I'd like to thank everyone who made an effort to attend our Open House this spring! As the official celebration our move to Boston, the Open House was a huge success. Hosting over 100 people, the party drew consumers, families, local treatment providers, and donors who all enjoyed an evening of wonderful food and drink, conversation, and networking. Over the course of the evening we were able to sign up multiple volunteers for the national office, assist several people in finding local treatment providers, and enjoyed a book signing by Dr. Michael Jenike and Ed Zine for their recent book *Life in Rewind*, also written by Terry Murphy. A special thanks to the office staff for making the night a huge success through all of their hard work.

I hope you all enjoy what is left of the summer. I am looking forward to seeing those of you who will attend the conference in Minneapolis. I thank all of you for your continued support of the OCF and the important work we do together.

Diane Davey

President, OCF Board of Directors

OCD NEWSLETTER

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The Obsessive Compulsive Foundation (OCF) 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:

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

FROM THE FRONT LINES

My Personal Journey with OCD: Before, During, and After Cognitive Behavior Therapy

By Nancy Mason

When I was nineteen years old I worked in a chemical plant in West Virginia. At the time I was feeling very depressed for various reasons, mainly because I could not afford to go to college like my friends. Suddenly I noticed that I had an urgent need to recheck whether or not I had flushed the toilet at work. I began to obsess about whether or not I had paid a bill, or about a white lie I had told. I barely slept and had to quit work. My mother kept taking me to our family doctor, who sent me to the local psychiatric ward to be evaluated since he could not find a cause for my illness. While there, I was so scared and I started to cry. They put me in a straight jacket. My family doctor got me released and I went home to suffer some more. Little did I know, but my journey with OCD had just begun.

In 1969 I married my wonderful husband and later had three beautiful children. I was blessed that during all of those years, while raising my kids, intrusive thoughts did not plague me. I had an occasional thought or felt like reaching out to touch someone in the grocery store. I thought it was because I was homesick. My husband was and is very supportive of me and my thoughts. Even before we knew it was OCD that I was suffering from he told me "everyone has awful thoughts sometimes."

In 1984, after a surgery, I went into a clinical depression. I barely slept or ate. I knew I had to do something, so I went to the psych ward of a local hospital in New York and stayed there for six weeks. It was the hardest thing I ever did but the best thing, too.

After leaving the hospital I worked with a doctor to start going off of an anti-anxiety drug, but I started to notice that normal behavior like being careful around a pair of sharp scissors turned into thoughts like, "What if I picked them up and stabbed someone?" or "What if I stabbed my dog with a knife while unloading the dishwasher?" I was confused because I knew I loved my pet and that I would never want to hurt her. My life became a nightmare of harmful and sexual thoughts. These thoughts were everywhere – I might run over someone with a car, touch someone inappropriately, stab the dog, say the "F" word, and so on.

While I was experiencing these thoughts a doctor never actually diagnosed me with OCD or even mentioned it. A friend who was a psych nurse gave me info about OCD and thought that's what it was. Later, my doctor agreed with the diagnosis.

Then I found a wonderful therapist. She confessed that she was not well educated about OCD, but she studied and we had a workbook to go by. I am also fortunate to have found the Central New York Obsessive Compulsive Foundation Affiliate support group in Utica, NY. The leaders of the group attended a national OCD conference around that time. They came home afterwards and told me about a form of therapy that involved making an exposure tape and writing a detailed story about actually acting out a harmful thought. I thought, "How could I ever do this?" It seemed the direct opposite of what I wanted to do, but my therapist Susan and I worked together to do it. I took my three most disturbing thoughts and used the hierarchy method. First I made a tape using my least disturbing thought, then the second, and finally my number one most disturbing thought.

I would sit by myself or with my dog and play the tape over and over, listening in detail about how I would stab the dog, the police would come, everyone would hate me, etc. The thoughts never became silly or funny or common, but habituation occurred. I got so used to hearing the tape that the thoughts lost their effect on me. I know now that people with OCD don't act on their thoughts; instead, they react to the fear of the thoughts. I had learned a coping mechanism. I had my first glimmer of hope. Let the thoughts come!

Now I don't run from the thoughts. I follow them through – for example, if I see a sharp knife in the dishwasher I say to myself, "Yes, I could stab my dog but I don't want to. I'd rather play with her." I breathe deeply and go on about my day. It is also worth noting that taking an OCD medication helped to calm down my thoughts enough so that I could concentrate on the cognitive behavior therapy (CBT).

I was fortunate that my therapist had educated herself about OCD. In 2007 she attended a Behavior Therapy Institute (BTI) run by the Obsessive Compulsive Foundation. The key concepts that she learned or that

were reinforced were: 1) the importance of a patient's treatment-readiness (working through resistance), 2) treatment-interfering behaviors, and 3) gaining detailed information on developing exposure hierarchies.

The therapy techniques that helped me the most were the exposure tapes, deep breathing exercises, keeping a journal, continually educating myself about OCD by reading many books, challenging the OCD by 'bossing it back,' and using metaphors to talk and think about my OCD.

I know how hard it is to find a qualified person to help with CBT for OCD. There is a desperate need for providers; psychiatrists are great to prescribe medication but few have the time to dedicate to CBT. My therapist significantly helped change my life for the better partly due to her experience at BTI. I would encourage any treatment provider to attend a BTI.

Did you know...

The Obsessive Compulsive Foundation now has a page on Facebook! If you have a Facebook account, search for "Obsessive Compulsive Foundation" and become a fan of the OCF! It's a great way to get updates about current events, read about new developments in OCF programs, and stay connected with the OCF community!



ocd

by Terry Mullaney

**Don't.
Leave me
be.**

**Don't
leave me
be.**

**I'm in here; alone, afraid.
Don't forget me
I'm in here
shouting, trying to stand.
But inside my blue marble,
it's cold and slippery.**

**I hear laughter through the noise.
Clouded vision filters light.
I know the difference.**

**Doubt wraps its cold arms
around my soul.
Painful confusion.
I'm in here.
Don't
leave me
be.**



FROM THE FRONT LINES

“Not Right” OCD and Interactive Storytelling

By Emily Kelley

My daughter Grace was diagnosed at age 7 with two daunting disorders: Attention Deficit Disorder and Obsessive Compulsive Disorder. In my parental frenzy I spent months devouring books and articles on both disorders. I found Grace in every ADHD book I read, but she never seemed to fit the classic mold of a child with OCD. She was definitely anxious and frequently needed reassurance, but exactly why the reassurance was needed was always a puzzle. She never expressed a fear of anything specific. She had the compulsions – a constant need to know that everything, in general, was “OK.” It was phrased more as a statement than a question: “It’s okay, Mommy” or “It’s alright,” and she always required acknowledgement from me, in the form of agreement, that, “Yes, everything is ok.” But what prompted these statements? It was never clear. This need for reassurance gradually grew to the point where it was required during every exchange of words between us. The elusive quality of Grace’s condition not only made it difficult to treat, but also complicated my ability to connect with her at home. Every attempt I made to talk with her about her condition was met with anger, frustration, and refusal. Where had my daughter gone? She had never been reluctant to share anything with me before and our bond had always been very strong, but this issue was pulling us apart. I knew that I had to become creative if I was ever going to help her.

Perhaps I was missing something obvious; after all a lot of problems with children are just misdirected attention-seeking. I began to spend extra time, each night, playing with Grace in her dollhouse. I thought that maybe, if I paid careful attention in this play, a clue might emerge. Grace was clearly less anxious during this time together, and it was enjoyable for both of us. But this “fishing expedition,” while enjoyable, did not provide the needed clues or bridge the gap. I could not connect with her in a way that was relevant to her condition. Sometimes, I would casually bring up the topic after a soothing bath and a cozy story. We had moments. In fact, I can recall one “breakthrough” moment where Grace, very relaxed after a bath, was open to discussing her OCD. I referred to some of the advice in the books, which suggested giving your child’s worry a name. I gave it a try. I said, “Grace, I’m so tired of this OCD monster bossing you around, and telling you what to do. Maybe if we give this monster a name, you can boss it back.” I asked her what she might like to name it. She became very excited, and decided on “Poopyface.” We laughed, and she began to angrily – and confidently – tell this “Poopyface” to get lost. I was so proud of her, and so sure that this was the beginning of her willingness to fight. I wish I could say that I was right; unfortunately, Grace gave up the fight as soon as it began. It just didn’t stick. I tried to remind her of her worry monster. But she became defensive in my willingness to help. She didn’t want my reminders. In retrospect, I think that Grace’s ADHD also complicated her ability to continue fighting. Her distractibility and lack of focus made it difficult for her to stay on track. But we were still stuck. It was back to the drawing board.

I went to the OCF annual conference, where discussions of “not right” feelings immediately caught my interest. It seemed like it was the most logical explanation for Grace’s distress. Why was she frustrated and anxious when I asked her to tell me what was wrong? All this anxiety and anger stemmed from her inability to explain it. It was an unidentifiable fear. It was just a feeling inside that something was not right, a problem that, by its very nature, is hard to define. This posed some challenges in trying to personify it. I had to approach her about this in a different way. I began by reading a book with her called, *How Are You Peeling?*. It described the various types of feelings we all have, which was illustrated with cute little carved and peeled fruits depicting the facial expressions that go along with these feelings. They were very creative, and immediately caught Grace’s attention. We slowly went through it together and, at the end, I said that a very important feeling had been left out, which was the “not right” feeling. Grace continued to look at the book, and nodded in agreement. But she made it clear that she did not want to talk about it. Although I was happy to see her acknowledge this feeling on some level, it would be impossible to help her if we couldn’t discuss it. It was time to try another tactic.

The answer presented itself at bedtime. Grace's vivid imagination has been focused on fairies that could show up at all times of day, but especially at bedtime. I realized that it might help if I tapped into this playful and imaginative side of her. One night, while Grace and I were playing together, I asked if she would like the fairies to speak to her through me. She was thrilled with the idea. I would "become" one of the many fairies that I had named, on a nightly basis, and we would talk. At first, it was getting to know the fairies, so we "talked" about such things as what games they like to play and their favorite snacks. But gradually, with the fairies doing the talking, her worries and struggles emerged. As with many children with ADHD, Grace sometimes has difficulty falling asleep at night and she had resisted doing any relaxation breathing – that is, until Goldenmist arrived on the scene, who has become Grace's "relaxation" fairy. When Grace has trouble falling asleep, Goldenmist will breathe along with her, and she will sometimes ask her to close her eyes, and imagine herself lying in a field full of beautiful flowers. With the help of Goldenmist, Grace is now doing her relaxation breathing.

Encouraged by this success, I invented Lilith who is also struggling with OCD. She's experiencing the same "not right" feelings and has become an ally to Grace in her fight. When I sense that her reassurance seeking is increasing, it is not me who reminds her of what she needs to do – it is Lilith. Lilith reminds her to ignore her "worry monster." She will tell Grace not to listen, and will say, "I know it's hard Grace. I have to do it every day. But I'm here for you. We are in this together." She has also joined Grace in talking back to her monster. When Grace feels as though she needs to know that everything is alright, Lilith will remind her that she must remember that this is her OCD making her feel this way. Although this has helped Grace tremendously in her fight, she has most recently expressed the need to know why her "worry monster" is so mean. Grace is a very sensitive child, who feels as though her worry monster might need help in order to be kind again. While playing the part of her worry monster I said, "I can become a good monster, but I need your help. You must ignore my demands. You cannot listen to me. If you can do this, I can change." Grace then said, "Could you become a Sparrow man?" (A Sparrow man is a male fairy). "Yes I can." I said. "With your help, I can be free." In light of this, Grace has changed the name of her monster

from Poopyface to Fluffy. While Lilith still talks to Grace when she calls her, Fluffy has now become her main focus. When Grace falls off track, He will remind her that in order to become a "sparrow man," she must continue to do her part.

With the help of these "fairies" and our joint story telling, Grace has become less anxious. It has been interesting to watch how the characters have evolved, in particular how OCD has been morphed productively into Fluffy. She will readily take advice from Fluffy that she would never accept from me. I have made sure that many of the fairies meet a particular need for Grace. Over time, I have come to realize that it is not just the content of the play that Grace has responded to, but it is the storytelling itself. The playfulness and a one-step-removed approach seemed to take the pressure off and made the effort more manageable. She has become calmer and happier, and although it is based purely on fantasy, it has nonetheless created an undeniable change in Grace's anxiety. In utilizing my daughter's imagination, as well as my own, I have come to realize what an enormous tool it can be in connecting with your child.

Grace continues to communicate with Fluffy and the fairies on a daily basis. Along with the right medication and therapy, she is improving. I was fortunate in obtaining the support of a knowledgeable psychiatrist, as well as a brilliant therapist, whose expertise was crucial in my ability to navigate my way through the "foreign land" known as OCD. This in turn allowed me a greater understanding of the role and purpose that each fairy must serve. I am playing pretend with my daughter every day and loving every minute of it. Knowing that it is helping her overcome this disorder makes it all the sweeter. But it is so important to emphasize that this playful communication has given form to the "not right feeling" part of OCD, which otherwise seems to evade easy definition.

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 subject should read: From the Front Lines.

ORGANIZED CHAOS: FOR TEENS & YOUNG ADULTS

A Teen's Life with OCD

By Ray

I have endured OCD off and on for over 4 years. I am now 15 years old and have had major OCD symptoms for about 1½ years. I am told that I had some symptoms even earlier on, but I was too young to really understand them. As many know, OCD is a terrible and painful mental experience that can leave a person and their loved ones broken until they are strong enough to stand up and fight what they fear the most. OCD has caused me so much mental pain and anxiety that at times I wanted to give up and cease to live; however, I always kept in mind that if I did, I would be giving in to this bully. I also would be leaving those who have fought so hard for me, a situation that is hardly fair. Instead, I have decided to work hard to rid myself of OCD.

My OCD took a fairly common turn. I obsess about sexual things that most people would find pleasurable and completely normal. Having obsessions about sexual things makes me sound like some kind of pervert, although I know that I definitely am not. I worry about harming small children or about getting “dirty” from touching my genital area. Another fear that I have is coming into contact with semen. I know that my obsessions make no sense to others. I am friends with extremely typical teenage males who are not afraid to talk about this topic and I stand out a bit because I don't. Most people find sexual matters pleasurable and just continue on with their lives. But for me, it is torture. At times, I am anxious to a level incomprehensible by most. During these episodes, the only ways that I can find to lessen my anxiety is to either “confess” to someone or to clean myself (i.e., multiple hand washings or showers). I can't find the words to explain this feeling to others, but it is somewhat like not being able to find something extremely important after just getting off a plane: you would fear you left it on the plane and would not be calm until you found it. This is how it is for me and OCD.

There came a time when my OCD was so bad that I needed help. For this, my mother turned to both a psychiatrist and a therapist. The psychiatrist just minimally listened to us and then handed us a prescription for pills. Overall, the psychiatrist only made me annoyed and did not help me feel better. From what I can tell, the medicine didn't play that much of a role in helping me. I did not notice any changes, nor did I feel anything different. However, my mother has noticed a lot more than I have in the medicine area. She thinks that the medicine did help me seem less anxious. As far as going to therapy, I think it helped me little to none. The only benefit that I can see is that it gave my mother some ideas on helping me. It seems that a lot of psychologists, at least in our area, don't have that much experience in treating OCD. My therapist just didn't seem to know the correct ways for helping me, and I really needed the help.

Even though the medicine and therapist didn't help as much as I would have liked, there was one thing that did: exposure and response prevention therapy. My mother had read a lot about this therapy and decided that we needed to try it. I have found that this therapy is the most helpful. Over one particular Christmas break my mother and I used this therapy and worked hard to get me over a lot of OCD symptoms. Since my obsessions concern sexual matters, we used things like human sexuality textbooks and movies to expose me to what I feared the most. The movies we watched had explicit scenes that related directly to my “bad thoughts.” I then waited a while before I washed my hands or took a shower (my most common compulsions when exposed). Because of all of our therapy, I can now go the entire day and take only one shower. Also, I no longer wash my hands as much as I used to. This Christmas-break therapy session was one of the hardest things that I have ever done. I really didn't want to do it, but my mother knew that it was very important for me. To get me motivated she told me that I would receive a cash reward at the end of the 2 week break for my hard OCD work. I admit that I was motivated to work hard for the money. I know that some people would have discouraged this approach, but for us it has worked and I now feel so much better (and a bit richer!).

Even though going through exposures helped me the most in dealing with OCD, there were other things that I used. I found that small pleasures in life can distract me from OCD and that if I engage in small projects I can feel more confident in myself and thus fight OCD better. One example of this is weight lifting. After investing several hundred dollars on exercise equipment, I started lifting weights. I made it my goal to lift a certain amount of weight and after I reached it, I set a new goal. It was an investment that was extremely worth it because I found that exercising has helped me tremendously. There were several other things that I used to fight OCD. There were times when I could not talk with my mother about what was going on with my OCD, but she needed to know what I was thinking. To help with this, we created separate personalities, with voices and all, out of our household cats. Even though this might sound weird, it works well. We have one "therapy" cat in particular whose personality we turn to when we feel bad and cannot communicate directly with each other. His name is Hank, and he is an extremely friendly and nice cat. Hank takes over and "talks" during especially difficult times. Even though it is really my mother who is directing the conversation, I find that "talking" with Hank helps us through our difficulties.

I am doing well now and hope to continue making progress. Looking back, though, I can see mistakes that both my mother and I made along the way. Most of these mistakes came up when my mother thought I could do something that I couldn't. I would have a lot of trouble explaining to her that I did not have the ability to do something that was OCD related. Because of this, we would argue and get annoyed with each other. At times, this caused me to get so mad that I would destroy things. It took us a long time to actually realize that our approach was not getting us anywhere and that we had to go slow and steady and to have lots of healing time between hard pushes of working on OCD.

Another thing that held us back was a lack of communication. Many times my OCD caused something to happen, but I would not tell my mother that it was because of the OCD. She and I would argue about whatever had happened and would get nowhere. For example, there were times that I threw away my homework and got a bad grade because it had somehow gotten "contaminated." During these times, I didn't want to tell my mother that my OCD had gotten in my way because she would insist that we talk about it. Even though I knew that it was important for me to handle my OCD there were times when I just couldn't face it.

There is no doubt that I hate my OCD and that I would not wish it upon anyone. However, having OCD has taught me some valuable things which I carry with me wherever I go. I now know that if I meet somebody who seems a bit strange that they may have a personal problem and are just trying to get through life like me. I do not make fun of people any more because of what I have learned through OCD. I have also learned about empathy. I can empathize with others because I have felt extreme guilt and sadness that may be similar to what others have felt. Because of OCD, I can better understand someone else's pain. I hope to someday help others who are struggling just like me and who are going through similar things that I have. I want to show others that having OCD is not the end of the world even though it is certainly a distinct hindrance to a good quality of life. Life can be ruined by OCD if it is not treated but, once OCD is recognized, it can be halted and a life can be made better.

We would like to start a new section called "Organized Chaos: For Teens & Young Adults" in the OCF newsletter. This new section will feature personal stories, creative writing, and artwork relating to the OCD experience of teens. If you are between the ages of 13-18 and are interested in sharing something, please email your submission to editor@ocfoundation.org. The subject should read: Organized Chaos.



THE THERAPY COMMUNITY

Deep Brain Stimulation for Highly Treatment-Resistant OCD

By Darin Dougherty, MD, and Benjamin Greenberg, MD, Ph.D.

Darin Dougherty, MD, is Associate Professor of Psychiatry at Harvard Medical School, Clinical Associate at Massachusetts General Hospital (MGH), Interim Director of the MGH Psychiatric Neuroimaging Group, Director of the Neurotherapeutics Division in the Department of Psychiatry at MGH, Visiting Scientist at Massachusetts Institute of Technology, and serves on the MGH Psychiatric Neurosurgery Committee and MGH General Clinical Research Center Advisory Committee. Dr. Dougherty is also an attending psychiatrist at the OCD Institute (OCIDI) at McLean Hospital outside of Boston, MA and serves as Director of Medical Education at the OCIDI.

Benjamin Greenberg, MD, PhD, is associate professor of psychiatry and human behavior at the Warren Alpert Medical School of Brown University. Dr. Greenberg is one of the world's leading experts on OCD and the development of neuromodulation treatments (especially deep brain stimulation) for severe, untreatable forms of OCD and depression.

While most patients with obsessive compulsive disorder (OCD) eventually respond to treatment with medication and/or behavioral therapy, a small minority do not improve following all conventional treatments. For this small minority, one of the few remaining options is neurosurgery, including lesion procedures (cingulotomy or capsulotomy) or deep brain stimulation (DBS). Cingulotomy involves drilling through the skull (called a craniotomy) and using a thermal (heated) probe to lesion an area within the anterior cingulate cortex of the brain.

Neuroimaging studies aimed at seeing what parts of the brain are involved in OCD have found that this area, the anterior cingulate cortex, is repeatedly involved (Deckersbach et al, 2006). Studies examining the outcome for patients following cingulotomy for treatment-resistant OCD have shown that almost one-half of patients who did not respond to conventional treatment achieve some benefit from the procedure (Dougherty et al, 2002). Another neurosurgery procedure that has been used for treatment resistant OCD is called capsulotomy. This procedure is named after another structure in the brain: the anterior limb of the internal capsule. Again this procedure makes lesions (holes) in a part of this brain structure (technically this is an "ablative" or lesion procedure). Positive outcomes following an anterior capsulotomy for OCD are approximately 50-60% (Greenberg et al., 2003; Ruck et al, 2008). While the original capsulotomy procedure also involved a craniotomy, the use of the "gamma knife" has more recently allowed for capsulotomy procedures that do not require opening the skull. The gamma knife capsulotomy involves passing multiple gamma rays through the skull. No single gamma ray poses any danger to brain tissue. However, where the gamma rays intersect, the energy level is high enough to destroy (or ablate) the targeted tissue. The most recent version of this procedure is called gamma ventral capsulotomy, in which the lesions are limited to the ventral (bottom) half of the anterior capsule. Responses to this procedure appear to be seen in about 60% of patients (Greenberg et al., 2003; Lopes et al., in press 2009).

Another important development for treatment-resistant OCD is deep brain stimulation (DBS). DBS has been used since the mid-1980s to treat movement disorders such as severe tremor or Parkinson's disease. DBS involves placing electrodes in targeted areas of the brain. In Parkinson's disease, electrical stimulation of the targeted brain region (such as the subthalamic nucleus) usually results in a significant decrease in some of the disabling symptoms of the illness, such as tremor. Once the electrodes are in place, they are connected by wires under the skin to pulse generators under the skin (usually just below the collarbone). The pulse generator or "implantable neurostimulator" contains a battery for power and a microchip to regulate the stimulation. The treating physician uses a hand-held wand and small computer to communicate with the pulse generator through the skin. In doing so, the treating physician can determine how much electrical stimulation is delivered in which manner through the stimulating electrodes. These pulse generators are very similar to those implanted under the skin (also usually just below the collarbone) for patients with cardiac pacemakers. The treating physician even uses a similar device to communicate with the pulse generator through the skin. The biggest difference is that in DBS the electrodes are in the brain instead of in the heart (as is the case with cardiac pacemakers).

Given the encouraging response rates following capsulotomy for highly treatment refractory OCD, investigators decided to test DBS in this area of the brain and first implanted electrodes in the anterior capsule in patients with treatment-resistant OCD in the late 1990s (Nuttin et al, 1999). The early results were promising as three of these first four patients experienced benefit. Since then, larger scale trials have been conducted and the target site has moved slightly to an overlapping part of the brain called the ventral capsule/ventral striatum (VC/VS). A recent report by Greenberg (2008) describes the current

worldwide experience with DBS for OCD. For the 26 patients with treatment-resistant OCD described in the Greenberg manuscript, 61.5% were considered responders to DBS. This response rate is comparable to or slightly higher than the response rates for the other neurosurgical options described above (cingulotomy and capsulotomy), but comparisons must be tentative since the numbers of patients treated with DBS are still relatively small. In addition, while DBS does require opening the skull, it does not require destroying any brain tissue. Lastly, DBS allows for a wider range of stimulation parameters (different amounts of electrical charge) than an ablative procedure.

Based on these results, the FDA recently approved DBS for treatment-resistant OCD under a Humanitarian Device Exemption (HDE). The HDE approval assumes that a relatively small number of patients will receive the treatment. Because DBS for treatment-resistant OCD is a very specialized procedure, it is recommended that treatment be rendered at institutions that have experience with this intervention. Appropriate patient selection is vitally important. Typically, patients eligible for DBS will have had minimal or no response to all currently available medication and behavioral treatments for OCD. It is also critically important that a neurosurgeon with expertise in "Stereotactic and Functional Neurosurgery" perform the procedure. Of course, treatment begins after electrode placement. Determination of optimal stimulation parameters and longitudinal treatment are crucial. It is crucial that a psychiatrist with expertise in DBS be directly involved in a patient's care over the months and years following surgery. At this point it appears that DBS needs to continue indefinitely for continued benefit. One of the most interesting clinical observations after lesion procedures (capsulotomy or cingulotomy) or DBS is that behavior therapy may become effective for a patient who was unable to improve with such treatment before surgery (Greenberg et al., 2006).

While the field of neurosurgery for treatment-resistant OCD has advanced considerably in recent years, further research is needed to both optimize DBS treatment and to better understand how DBS works (which areas of the brain are affected and how). Currently, four institutions are funded by the National Institutes of Health to conduct further studies of DBS for OCD. They are listed below. It is recommended that if a patient or treater is interested in learning more about these clinical trials that they contact one of these institutions. While these are exciting times for OCD treatment, there is still much to be learned.

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The Relationship Between Eating Disorders and OCD: Part of the Spectrum

By Fugen Neziroglu, Ph.D., ABBP, ABPP and Jonathan Sandler, BA

Fugen Neziroglu, Ph.D., is a board certified Behavior and Cognitive psychologist involved in the research and treatment of OCD for 25 years. She is the Clinical Director of the Bio-Behavioral Institute in Great Neck, NY and Professor at Hofstra University. She is a member of many national and international societies and is on the Scientific Advisory Board of the OCF. She provides direct therapeutic services, supervises assistant psychologists, sponsors doctoral dissertations and conducts research.

Jonathan Sandler, BA, is a research assistant at the Bio-Behavioral Institute in Great Neck, NY. He is involved in the research of Obsessive Compulsive Spectrum Disorders and is currently in charge of two main projects: studying disgust reactions and studying the perception of facial flaws among the various spectrum disorders. Anyone interested in finding out more about how these two phenomena may be related to one's own concerns may contact him at Bio-Behavioral at (516) 487-7116.

When people think of eating disorders they conjure up images of adolescents performing rituals around food and obsessing about what to eat, how much, whether the food will be easily digested or whether the food will sit in their stomachs and make them look ugly. Others think of individuals with eating disorders appearing very similar to those with body dysmorphic disorder, both being very preoccupied with their body image. However, most people do not think of eating disorders as being part of the OCD spectrum and the relationship between the two disorders has gone relatively unstudied. Even more troubling is the fact that, when patients seek help from mental health professionals in order to alleviate their suffering, clinicians may often mistake one for the other. In other words, since the behaviors that result from both OCD and eating disorders may appear so similar, it might be difficult to determine which of the two disorders the patient actually has if both are simultaneously present and, if so, which disorder is mainly responsible for bringing about the other.

Ever since 1939, researchers have speculated on the parallels between OCD and eating disorders. Numerous studies have now shown that those with eating disorders have statistically higher rates of OCD (11% - 69%) and vice versa (10% - 17%). As recently as 2004, Kaye et al. reported that 64% of individuals with eating disorders also possess at least one anxiety disorder, and 41% of these individuals have OCD in particular. In 1983, Yaryura-Tobias and Neziroglu proposed that eating disorders may be considered part of the OCD spectrum but since then the boundaries among anorexia nervosa, bulimia nervosa and OCD remain blurred.

Thus, the challenge for clinicians becomes recognizing whether the condition is a particular form of OCD or actually an entirely separate, but related, disorder with symptoms that merely have an obsessive-compulsive quality to them. More specifically, individuals who suffer from anorexia commonly diet and exercise excessively; those with bulimia usually develop a vicious cycle of bingeing and purging. In both instances, extreme and often life-threatening behaviors that consist of either consuming too little or too much food typically stem from intrusive, obsessive thoughts. Anorexics in particular exhibit faulty perceptions of body image, an irrational fear of gaining weight, and other food-related obsessions, thereby leading to the categorical refusal to eat. As for bulimics, their disorder is characterized by a consumption of abnormally large quantities of food, followed by overwhelming feelings of guilt and shame. In other words, the sense of helplessness or lack of control they experience during binge periods ultimately gives way to obsessions of physical sickness and self-disgust afterwards.

In the cases of both anorexia and bulimia, obsessions lead to levels of anxiety that can only be reduced by ritualistic compulsions. The compulsive behaviors of anorexics can often be seen in their careful procedures of selecting, buying, preparing, cooking, ornamenting, and eventually consuming food. Just as with OCD, compulsions are commonly strengthened by many other personality traits, such as uncertainty, meticulousness, rigidity, and perfectionism (Yaryura-Tobias et al., 2001). Anorexics also often exhibit overvalued ideation, cognitive distortions such as all-or-none thinking, and attempts to gain control of their environment. For bulimics, the need to feel relieved of the obsessive guilt and shame following binges causes them to compulsively purge the food they consumed, repeating the cycle over and over again. Here too, perfectionism, an excessive desire for social approval or acceptance, and bouts of anxiety or depression play a major role.

In both anorexia and bulimia, the individual clearly becomes preoccupied by incessant thoughts revolving around body image, weight gain, and food intake, leading to ritualistic methods of eating, dieting, and exercising. The common thread linking both of these disorders to OCD is the overwhelming presence of obsessions and compulsions that eventually affects the individual's daily functioning even to the extent of becoming incapacitated. Just as the OCD sufferer feels as though the door is not locked, despite evidence to the contrary, and is then compelled to check those locks hundreds of times in order to remove this doubt, so too the anorexic feels as though she is fat, despite the reality the mirror portrays, and she is thus forever checking her stomach to make sure that she has not gained weight but she is never satisfied and therefore she is compelled to lose weight by any means necessary. As with an OCD sufferer who can never achieve that "just right" feeling on a specific task, so too is a bulimic prevented from ever reaching his or her goals of fullness and emptiness in an endless binge-purge cycle.

Going one step further, there are many instances in which patients demonstrate behaviors that, at first glance, appear to be indicative of an eating disorder, but actually turn out to be a result of OCD. As an illustration, consider the OCD sufferer who may lose weight excessively and appear anorexic, yet is doing so merely as the result of contamination concerns or time-consuming rituals that prevent him or her from eating on a regular basis. Conversely, consider the anorexic patient who seems to be engaging in obsessive-compulsive rituals of cutting or weighing food, yet only doing so in the hopes of restricting food intake and losing weight in the process. The potential for one disorder to appear as the other is virtually endless; below is just a small list comparing the very different underlying causes of strikingly similar behaviors in individuals with obsessive-compulsive disorder versus those with eating disorders:

OBSESSIVE COMPULSIVE DISORDER

- Individual counts the number of mouthfuls chewed or pieces of food in a meal, according to some fixed or magical number that is "correct" or "just right" and thus effectively losing more
- Individual repeatedly washes hands, due to a fear of germs, contact with waste products, or a number of other sources of possible contamination that exist
- Individual throws out food in a can that has been lightly dented, for fear that it might contain food poisoning and later cause serious illness to person
- Individual repeatedly asks waiter in restaurant about different dishes on menu, doubtful that he or she has enough knowledge to make the perfect meal decision
- Individual refuses to enter kitchen in order to eat due to fear of accidentally mixing cleaning items with the food
- Individual repeatedly checks refrigerator, shelves or other parts of house, in order to make sure that every piece of food bought is in its proper, designated place

EATING DISORDERS

- Individual counts mouthfuls or pieces of food as a means of limiting portions and thus effectively losing more weight
- Individual excessively washes hands to remove trace amounts of oil that might cause weight gain if ingested
- Individual throws out food in a can because it was discovered to contain poisoning and later too many calories upon reading label
- Individual constantly asks same waiter different dishes about contents of dishes, so as to stay enough knowledge to make the away from having any butter, oil, or fat
- Individual refuses to enter the same room, for it will only lead to the temptation to eat and thus get fat
- Individual constantly checks same locations, in search of food to eat in an extensive bulimic binge period

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(Relationship Between Eating Disorder, continued)

Thus, in order to differentiate between the two disorders and make the proper diagnosis, it is crucial for the clinician to more closely examine the specific behaviors that are being observed and the motivations behind those behaviors. Whereas patients with eating disorders are primarily driven by concerns of physical appearance and consequently alter their eating patterns in order to lose weight accordingly, OCD patients may be restricting their eating for reasons very different than body image concerns. Furthermore, for cases in which an individual qualifies for both diagnoses, such as an anorexic or bulimic who also experiences non-food related OCD symptoms like checking or contamination, it is still imperative to consider whether or not their symptoms are being motivated by both disorders simultaneously. For example, consider a patient washing his/her groceries due to the fear of contamination, as well as the fear that the products may contain high fat ingredients.

It should be noted that the recommended psychological treatment for both OCD and eating disorders usually involves some combination of cognitive-behavioral therapy, antidepressant medication, and family counseling. Successful treatment for bulimics, in particular, often entails classic exposure and response prevention, in which patients are exposed to their favorite foods, asked to eat, and then prevented with careful monitoring from vomiting, using laxatives, or otherwise purging. Additional techniques involve gradual alteration of eating rituals and increased flexibility in eating behaviors, which may include breaking rituals such as the need to use the same utensils, to measure food, to time meals, and to avoid certain restaurants. Because eating disorders typically result in numerous medical complications, we strongly encourage physicians and nutritionists to be part of the team.

Significant advancements have recently been made in both the diagnosis and treatment of OCD and eating disorders as separate entities, but ample scientific research into the connection between the two, the commonality of their symptoms, and the possible biochemical similarities behind them is presently lacking. Fortunately, some of the most promising psychiatric investigations into the overlapping symptoms of spectrum disorders have focused on these neurophysiological similarities. One such study asked participants to engage in a task believed to activate the prefrontal cortex and caudate nucleus of the brain, so as to compare the performance of participants with OCD to that of those with anorexia. The study found that both groups had difficulty with the task and had higher cerebral glucose metabolism, suggesting a connection between the two disorders and offering evidence that "ritualized, obsessive and compulsive behavior (with reference to eating disorders as well as washing and checking OCD) could have its origin within common neurobiological abnormalities" (Murphy et al., 2004).

Although such results are clearly signs of progress, they are still indirect and speculative at best. More work is therefore needed in order to properly isolate the clinical symptoms, biochemical factors, and genetic causes behind OCD and eating disorders. In one of our studies, we found that obsessive-compulsive overeaters responded to exposure and response prevention, while another group of overeaters responded better to more traditional stimulus control methods of treatment (Mount & Neziroglu, 1991). This shows that those eating disorders that are similar to OCD may respond better to treatment strategies used to treat more typical OCD behaviors. Consequently, for the sake of all those who suffer, the obsessive-compulsive related disorders need to be studied further in order to enhance our understanding of their similarities and dissimilarities. In doing so, we will hopefully not only arrive at better treatment strategies, but also increase our knowledge of the psychological and biological mechanisms by which the disorders develop.

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The Treatment of OCD in Young Children

By Golda S. Ginsburg, Kimberly D. Becker, Marcy Burstein, and Kelly L. Drake

Golda S. Ginsburg, Ph.D. is an Associate Professor of Psychiatry and Director of Research in the Division of Child and Adolescent Psychiatry at The Johns Hopkins University School of Medicine (JHU). Dr. Ginsburg is an expert in the assessment, prevention, and treatment of childhood anxiety disorders and has published numerous articles and book chapters on this and related topics in child psychiatry. Dr. Ginsburg's research has been funded by grants from the National Institutes of Health and the Obsessive Compulsive Foundation, which funded the pilot study in this article. Drs. Becker, Burstein, and Drake are postdoctoral fellows at JHU and experienced CBT clinicians who have also published numerous articles in the area of child anxiety.

Daniel's Story

Daniel was a 7 year old boy who lived with his parents and two sisters. Daniel had obsessive thoughts about morphing into someone/something else, particularly after eating or touching something he believed was "contaminated." If the television was on during a meal, Daniel worried that he would turn into one of the television characters. These fears were very distressing for Daniel, who either avoided these situations or performed compulsive behaviors, such as holding his mother's hand while he ate. He refused to take a bath in "contaminated" water or wear clothes from previous seasons because he feared he would turn into a younger boy. He also worried about sleeping in his bedroom because he thought he would turn into one of his stuffed animals or worried that he would turn into animals he saw on or in his textbook, so he avoided looking at or opening his book.

Michelle's Story

Michelle was a 3 year old girl who lived with her parents and younger sister. Michelle's primary OCD symptoms involved strict adherence to order and routines. Michelle compulsively closed all the drawers and doors in her house, arranged her toys in a particular way, and insisted her mother complete their morning routine in a certain order (e.g., get dressed, then eat breakfast). When her mother took her on errands, Michelle insisted they visit stores in a specific sequence. If routines were not followed, Michelle repeatedly asked questions and sought reassurance. Michelle also exhibited an intense desire to be "first" across a number of situations. She had to be first to touch the door when leaving the house, first to reach the top of the stairs, and first to use the bathroom. If she were not first, she became distressed to the point of having tantrums. Michelle also exhibited signs of perfectionism, such that she consistently refused to try something (e.g., games, activities) unless she knew that she would win and/or succeed.

OCD and Families

The stories of Daniel and Michelle illustrate how distressing and impairing OCD can be, even for young children. Yet the impact of OCD extended to their families as well. Daniel's parents were very distressed by his fears. To ensure that he would not become upset, they turned off the television during mealtimes, held his hand, and made sure that any "scary" objects were out of sight. The family also avoided eating at restaurants so that Daniel would not come into contact with "contaminated" food. Daniel's refusal to bathe or sleep in his bedroom resulted in arguments with his parents and they allowed him to sleep in their bedroom. The impact of Daniel's OCD even extended to school, where his teacher removed objects that Daniel indicated were "scary" and kept them in a closet out of view.

Similarly, Michelle's parents were very concerned about how distressed she became when things were out of order or when routines were not maintained, so they went out of their way to stick to routines at home and in the community (e.g., shopping at stores in Michelle's preferred sequence). They consistently allowed her to be first and close doors/drawers when she desired, and they provided reassurance when she became upset. At preschool, Michelle's teachers kept doors closed and allowed her to sit out of novel activities.

It is common for parents and others to try to minimize the burden of OCD by helping their child avoid OCD triggers or by allowing them to engage in compulsive rituals (a term referred to as "accommodation"). As in

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(OCF in Young Children, continued)

both cases presented, many families structure their routines and activities so they can help their child avoid anxiety-provoking situations. Indeed, it seems reasonable that accommodating a child's OCD would decrease their symptoms and allow them to function. However, continued avoidance and/or reassurance can actually maintain OCD symptoms. The good news is that family-based treatments may provide parents with strategies to help manage and reduce their children's OCD symptoms.

Behavioral Treatment of OCD in Children

Cognitive-behavioral therapy (CBT; namely exposure and response prevention or ERP) is an effective treatment for childhood OCD, yet there are a few reasons CBT may require some modifications in order to be effective for younger children. First, some components of current CBT treatments (e.g., cognitive restructuring) may be too developmentally advanced for young children. Second, because family members frequently make accommodations (e.g., help child avoid OCD triggers) that maintain OCD, it is necessary to teach family members new ways of responding to OCD symptoms. Third, because OCD can cause frustration and conflict among family members, it might be useful to strengthen the parent-child relationship and teach strategies for parental stress reduction and problem-solving. Many CBT interventions do not offer these additional parent-focused treatment components.

At the Johns Hopkins University School of Medicine's Division of Child and Adolescent Psychiatry, we developed and tested a 12-week family-based CBT intervention to address each of the issues noted above. First, we adapted traditional CBT strategies, particularly psychoeducation and ERP, for use with our sample of young children. Given that it is challenging for young children to follow recommendations independently, parents became co-therapists in treatment, learning ERP and guiding their child's practice exposure at home. Second, we taught skills to reduce parenting behaviors that are thought to maintain and/or worsen OCD symptoms in children. Third, we taught parents specific strategies to solve problems, reduce family conflict, and strengthen the parent-child relationship through daily one-on-one time.

Our Family-Based OCD Treatment Program for Young Children

The treatment consisted of 12 weekly 1-hour sessions delivered to each family individually. Parents and children attended the first session together and received education about OCD and the CBT treatment model. Additionally, therapists introduced the importance of regular parent-child play time (with child taking the lead) to establish a positive context that would facilitate parents' ability to change their child's OC behaviors.

The second and third sessions, attended by parents only, diverged from typical CBT interventions by introducing specific parenting strategies to target OCD. With the help of the therapist, parents "mapped" OCD by describing the situations in which their children experienced difficulties with symptoms. Parents also provided information about their responses to their child's OCD, particularly with regard to family accommodation (e.g., in Daniel's case, putting away "scary" objects while he ate). Therapists instructed parents in how to use attention, praise, and other rewards when their child faced his or her fears (e.g., in Daniel's case, taking a bath), as well as how to reduce OCD-related symptoms by ignoring certain behaviors (e.g., in Michelle's case, her parents were instructed to ignore excessive reassurance-seeking). Parents and therapists jointly developed a plan to gradually decrease family accommodation and help the child face fears.

Starting with session 4, parents and children participated in exposure and ritual prevention (ERP), or helping the child gradually face his/her fears while refraining from doing their compulsive ritual (e.g., in Daniel's case, eating a snack while looking at increasingly bothersome pictures in books). This was done both in session and at home. Because of the children's young age, parental mastery of teaching/coaching their child to engage in exposures was critical and parents were given corrective feedback during the session. To enhance motivation and success, children had the opportunity to earn small prizes for engaging in exposures and special fun time with a parent was scheduled into the family's daily activities.

Parents attended session 7 alone, and therapists taught parents problem-solving skills to enhance their ability to solve problems effectively and reduce family conflict. Sessions 8 through 10 were attended by parents and

children together and involved continued practice with ERP. During session 11, families reviewed the skills they had developed throughout treatment and learned how to plan for future stressors in order to prevent the recurrence of OCD. The final session (12) included parents and children together during which time a final ERP was conducted and treatment progress was reviewed and celebrated.

Closing Remarks

Our program represents a modified CBT treatment that incorporates skills designed to reduce parenting behaviors associated with maintaining OCD symptoms and strategies to improve the parent-child relationship using a family-based format. In our pilot study of seven families, results indicate that the intervention was associated with an average of 44% reduction in OC behaviors. Also, by the end of treatment, parents spent less time supporting, assisting, or allowing children to engage in compulsions. Additionally, parents reported that their child's OC symptoms caused fewer problems with family activities (e.g., going to restaurants, visiting relatives), social interactions (e.g., playing with a friend, being with a group of people), and completing tasks of daily living (e.g., going shopping, doing chores, grooming). Thus, the treatment led to clinically significant changes in actual functioning. In sum, our study contributes to a small but growing body of work that supports the notion that there are effective family-based behavioral interventions for treating very young children with OCD.

OCF 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 OCF. The OCF'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

Anxiety Treatment Center of Sacramento Announces New "Sister" Program

Like The Anxiety Treatment Center, the new Cognitive Behavior Therapy Center of Sacramento will offer individual, group and family therapy services, as well as an Intensive Outpatient Program five days per week, four hours per day. Both of these facilities offer housing (Serenity House) located just minutes away for those who are traveling from out of town. For more information, please contact Robin Zasio, Psy.D. at (916) 366-0647 or go to www.AnxietyTreatmentExperts.com or www.CognitiveBehaviorExperts.com.

NEW YORK

Bio-Behavioral Institute Announces New Intensive Treatment Options

For those interested in the Bio-Behavioral Institute's comprehensive extended-stay intensive outpatient programs (IOPs), please inquire about recently improved extended IOP coverage options, usage of Acceptance and Commitment Therapy (ACT) and Dialectical Behavior Therapy (DBT) as an adjunct to Exposure and Response Prevention (ERP), as well as potential scholarship assistance.

For further information on all programs and services as well as upcoming events, presentations, and staff articles, feel free to contact Bio-Behavioral at (516) 487-7116 or visit their website at www.bio-behavioral.com.

PENNSYLVANIA

Western Psychiatric Institute and Clinic Bids Fond Farewell to Medical Director of its OCD Intensive Outpatient Program for Children and Adolescents

Andrew Gilbert, MD, the current Medical Director at the Child Intensive Outpatient Program (IOP) at the Western Psychiatric Institute and Clinic (WPIC) will be leaving the Pittsburgh area to move to New York at the end of the summer. Dr. Gilbert has been a major force in providing exceptional pediatric mental health care at WPIC and played a pivotal role in the formation of the clinic, seeing patients for their medication needs, coordinating their treatment protocols and working closely with the staff to ensure that the treatment provided in the clinic was the best that could be offered. His hard work and dedication have inspired and helped many, and we wish him luck in his future endeavors.

You need not worry about the status of the Child OCD Intensive Outpatient Program, as WPIC remains dedicated to continuing these services. Dr. Shoshanna Shear will be joining the Pediatric program on July 1st and will assume the Medical Director position on August 29th, and Dr. Amy Kelly will also be joining the program in August 2009. In November 2007, the administration of the Pediatric program was assumed by Carol Van Zile, LCSW, Program Manager.

WISCONSIN

OCD Center at Rogers Memorial Hospital Expands Bed Capacity

The Obsessive Compulsive Disorder Center at Rogers Memorial Hospital is pleased to announce that it has expanded its bed capacity from 8 beds to 16 beds. The expansion was a result of the hospital's recognizing the need for quicker availability of their intensive treatment services. The staff at Rogers Memorial would also like to thank the greater OCD community for its support of their OCD Center as they celebrate their 10th anniversary this year.

RESEARCH NEWS

2009 Research Award Recipients, continued**A FAMILY STUDY OF COMPULSIVE HOARDING**

*Jack Samuels, PhD, Assistant Professor of Psychiatry
Johns Hopkins University, Baltimore, MD
Total Award Amount: \$49,660*

There are major gaps in our understanding of compulsive hoarding. What are the genetic and environmental causes of compulsive hoarding? What is the relationship of compulsive hoarding to OCD? Is compulsive hoarding related to how the brain processes information (“executive functioning”)? A family study is a useful approach for beginning to answer these questions. The aims of this study are to determine if: 1) compulsive hoarding runs in families; 2) compulsive hoarding and OCD share a common family link; 3) specific domains of executive function underlie compulsive hoarding; and 4) specific childhood adversities are potential environmental risk factors for compulsive hoarding. We plan to recruit 50 adults with compulsive hoarding and 125 of their relatives (parents, siblings, and children). As a comparison group, we also plan to recruit 35 individuals without compulsive hoarding and 90 of their relatives. Participants will be interviewed by telephone using self-report instruments to evaluate compulsive hoarding, OCD, childhood adversities, and different aspects of information processing (for example, memory, decision-making, inhibiting responses, shifting attention, initiating and monitoring tasks, and planning and organizing activities). We anticipate that the results of the study will contribute to understanding the causes of compulsive hoarding. Moreover, we hope to determine if hoarding and OCD “run together” in families, which would support a genetic connection between these conditions. In addition, if specific difficulties in information processing (for example, making decisions, organizing, and planning tasks) are found to be passed along in families of individuals with compulsive hoarding, then these may be fundamental to the development of the condition, and may be targets for future approaches for treatment and prevention.

VISUAL ATTENTION BIAS IN BODY DYSMORPHIC DISORDER

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Total Award Amount: \$34,644*

Body dysmorphic disorder (BDD) is a severe disorder associated with substantial distress, reduced quality of life, social and academic/occupational impairment, hospitalization, and suicide. BDD is relatively common; therefore, the identification of risk factors and effective treatment strategies is critical. Cognitive-behavioral models of BDD highlight the role of information processing biases in the development and maintenance of the disorder. Specifically, people with BDD show a tendency toward detailed information processing, or over-focus on small details instead of the big picture—for example, selective attention to specific or minor aspects of appearance. Information processing biases trigger negative emotions (e.g., anxiety, depression, shame) and further excessive attention to perceived appearance flaws, which then leads to rituals (e.g., mirror checking, reassurance seeking, camouflaging) and avoidant behaviors. Cognitive and emotional information processing biases are well documented in clinical observation and neurobiological studies; however, early stages of processing (e.g., visual) have not yet been fully explored in BDD and may play a critical role in the development and maintenance of the disorder. Eye tracking is an innovative technology that has already been used to examine visual attention in other populations, including eating disorders. In the current study, we will use eye tracking to examine visual attention in 20 individuals with BDD (primary face/head concerns) relative to 20 healthy controls during a task in which participants observe photos of their own face and a control face and provide ratings of distress and perceived attractiveness of facial features. Cognitive behavior therapy (CBT) has been shown to reduce information processing biases in disorders similar to, and often associated with, BDD (e.g., OCD, social phobia, eating disorders), but this has yet to be explored in BDD. Thus, we will also explore the relationship of visual attention bias to treatment outcome to determine if visual attention bias improves following a brief behavioral therapy intervention.

ANTERIOR CINGULATE DEFICITS IN OBSESSIVE COMPULSIVE DISORDER

*Patricia Gruner, PhD, Post Doctoral Research Fellow
The Feinstein Institute for Medical Research,
Manhasset, NY
Total Award Amount: \$40,855*

Abnormalities in a brain structure called the anterior cingulate are believed to play an important role

in OCD. Prior brain imaging studies suggest that the anterior cingulate is overactive in individuals with OCD, and that it is particularly active when an individual experiences symptoms. The anterior cingulate plays a key role in detecting errors in the environment and may send signals to surrounding brain regions when an error is made or the individual believes that something is wrong. This could explain why individuals with OCD experience the need to correct their actions repeatedly even when they have not made an error. In this study we plan to study the integrity of the anterior cingulate in 15 pediatric patients with OCD and 15 age- and sex-matched healthy volunteers using noninvasive brain imaging techniques. We will use diffusion tensor imaging to investigate the anterior cingulate white matter, which forms the physical foundation for connections throughout the brain. In addition, we will use functional magnetic resonance imaging, which allows us to measure brain activity, while individuals perform a task associated with a high or low likelihood of error. By combining these techniques we hope to improve our understanding of the role that the anterior cingulate plays in the neurobiology of OCD. Abnormalities in this brain region could one day potentially serve as a marker for treatment response and provide critically needed information to inform genetics studies.

WHOLE EXOME SEQUENCING IN OCD PATIENTS

*Guy A. Rouleau, MD, PhD, Professor,
Department of Medicine
University of Montreal, Montreal, Canada
Total Award Amount: \$55,250*

We increasingly understand OCD to be a complex disorder of the brain. More and more evidence suggests that OCD symptoms are due to a malfunctioning of synapses (the areas of contact between different nerve cells that are critical for communicating signals throughout the brain and the body). The few genes that have been linked with OCD are involved in the development or maintenance of synapses. Studies in OCD twins and families suggest that OCD is highly heritable. However, traditional genetic approaches to discovering OCD genes have had limited success. We propose to use a new approach, looking at all the genes in a small number of OCD individuals in an attempt to identify possible mutations. We will start by studying the exons, or portions of the human genome that encode protein. We will

then use a procedure called “Next Generation Sequencing” to determine the DNA sequence of each exon. By doing this, we can compare the exons to look for variants which we believe might disrupt the gene and therefore the protein. We will confirm the problematic genes or proteins by studying mutations found in these genes in a larger group of OCD affected individuals and “normal” individuals. We expect that this approach will lead to the identification of variants in a small number of genes that can predispose to OCD, give us insight into the disease mechanism (for instance, imbalances in certain brain chemicals, or altered synapse structures), and may lead to novel therapeutics or treatments.

AFRICAN-AMERICANS WITH OCD: REDUCING BARRIERS TO DIAGNOSIS AND TREATMENT

*Monnica Williams, PhD, Assistant Professor
Center for the Treatment and Study of Anxiety,
University of Pennsylvania, Philadelphia, PA
Total Award Amount: \$37,400*

African-Americans experience OCD at similar rates as the general population but are less likely to receive treatment. Even among those who get professional help, few receive evidence-based treatment, such as exposure and response prevention or anti-depressant (SSRI) medication. African-Americans are virtually absent in OCD specialty clinics and clinical research studies. We don't know why African-Americans aren't getting help, how they cope with the disorder, if African-Americans tend to obsess about different things, or how effective conventional treatments are for this group. We will conduct a comprehensive assessment of 40 African-American adults with OCD from the Philadelphia area. This study has three important goals. First, we will examine the reasons that African-Americans do not receive specialized treatment for OCD so that we can develop guidelines for clinicians to improve outreach to African-Americans with OCD. Second, we will identify the reasons that African-Americans do not participate in OCD treatment-outcome studies and provide guidelines for researchers to improve recruitment and participation. Finally, we will examine how well our clinical screening questionnaires work in identifying OCD in African-Americans. This study is intended as a first step toward future goals of greater African-American inclusion in treatment and research opportunities.

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.*

In recent years, researchers exploring the complexities of OCD have taken a special interest in the issue of memory. Specifically, some have wondered if memory-processing difficulties or forgetfulness can cause or contribute to certain obsessive and compulsive behaviors such as checking, repeating, and doubt. Although some studies demonstrate a relationship between OCD and memory problems, other studies do not support a “memory deficit hypothesis” for OCD.

With the continued investigation of memory and OCD, however, many interesting questions have been raised. For example some now wonder if, instead of memory dysfunction possibly *causing* or *contributing* to repetitive behaviors, it might be possible that checking and other repetitive behaviors impact memory in a way that can actually lead to memory difficulties.

Researchers have also studied “memory confidence” and “memory vividness” in individuals with OCD. Is it possible that OCD patients are less confident in their memory, or might they lack clarity in their memory? Could it be the perception of one’s memory that leads to repeated checking or the doubting behaviors of OCD? In other words, some research has investigated whether repeated checking can actually *cause* memory distrust rather than enhancing one’s certainty about an event or situation. For example, someone with OCD might ask, “Did I really unplug the iron, or am I merely recalling another time when I did?”

Another way of putting it is, should we be more interested in the extent to which repeated checking might *lead to* memory difficulties or *add to* the patient’s uncertainty or confidence regarding his or her own recollections, or should we continue to investigate the possibility of memory deficits as a possible cause of OCD behaviors?

Although this introduction has focused on the issue of memory and OCD, it is important to point out that other aspects of cognitive function have also been investigated in OCD patients, including such things as attention, organizational and planning skills, and various aspects of information processing.

In this Research Digest, we have summarized the results of five recent studies that look at various aspects of memory and cognition in relation to OCD. Although uncovering causes of repetitive behaviors might appear to be the main focus of much of this research, the ultimate goal expressed in many of these studies is the hope that research of underlying causes will lead to more effective treatment strategies for OCD.

Checking-in on the memory deficit and meta-memory deficit theories of compulsive checking

Clinical Psychology Review, 29(5):393-409, 2009, C. Cuttler and P. Graf

In this comprehensive review, the authors summarize the findings of previous studies of memory and meta-memory in individuals with OCD. Their main objectives for this review were: 1) to determine if there are memory deficits unique to compulsive checkers or if the same deficits are found in individuals with other types of OCD (non-checkers); and 2) to examine whether it is only *retrospective* memory deficits (memory of past actions or events) that are found in compulsive checkers, or if *prospective* memory (the ability to plan and remember to carry out a plan or action) might also be a factor. From their review of existing studies, the authors make several interesting observations, and they also include several suggestions

for the future study of memory and OCD. For example, the authors point out that most studies have focused on retrospective memory (they found more than 60 studies). Only a few studies of prospective memory exist (they identified only 4 studies). The overall findings of the retrospective memory studies do not support a deficit unique to or more severe in checkers. In fact, from their review, they conclude that similar patterns of retrospective memory are seen in both checkers and non-checkers, meaning that deficits of retrospective memory are unlikely to cause or contribute to checking compulsions. They also make the observation that if memory deficits are similar regardless of OCD subtype, then memory deficits might be the consequence or result of some other factor, such as depression, medications, or certain brain abnormalities involved in OCD. Also, both OCD checkers and non-checkers seem to show greater deficits in

meta-memory (memory confidence) than in memory. Some studies of prospective memory involving subclinical checkers do show differences in checkers compared to non-checkers. However, since there are so few studies on this topic, it is not possible to reach any firm conclusions at this time. The authors suggest that prospective memory might be a better focus for future studies of memory and meta-memory in compulsive checkers, since checkers are concerned with actions that involve prospective memory (e.g., remembering to turn off the stove or unplug the iron before leaving the house). In conclusion, the findings of this review argue against a memory or meta-memory deficit specific to compulsive checking. The authors make the argument that current memory and meta-memory deficit theories of compulsive checking might be too general. They argue that it may be important to look closer at specific memory domains, such as

specific areas of prospective memory and also how other symptoms commonly found in compulsive checkers (worry, perfectionism, responsibility, etc.) might interact or contribute to memory and meta-memory deficits.

Differences in neuropsychological performance between subtypes of obsessive-compulsive disorder

Australian and New Zealand Journal of Psychiatry, 43(3):216-226, 2009, M. Nedeljkovic, M. Kyrios, R. Moulding et al.

Previous studies have reported deficits in neuropsychological test performance in patients with OCD. The purpose of this study was to determine if differences in test performance exist among OCD patients, based on OCD subtype. 59 OCD patients and 59 control subjects participated in this study. Various neuropsychological tests (from the Cambridge Neuropsychological Test Automated Battery [CANTAB]) were administered to four specific OCD subgroups (checkers, washers, pure obsessional, and patients with mixed OCD symptoms), and also to the control group of non-OCD individuals. Included were tests of executive function, visual memory and attention. Poorer performance by individuals with OCD, compared to the control group, was reported for most of the tests that were given. Also, significant differences among OCD subtypes were reported for some of the tests. For example, checkers were found to exhibit a greater impairment on a range of tests compared to the control group and to other OCD subtypes. Other differences among OCD patients were also reported, but the results are too detailed to include in this abstract. Although the findings of this study do give support for some differences in neuropsychological performance among the OCD subtypes, the authors point out that more studies are needed in order to confirm these results. If further research gives support for subtype differences, this information may have significant implications for treatment, based on OCD-subtype.

Metacognition and episodic memory in obsessive-compulsive disorder

Journal of Anxiety Disorders, 23(5):624-631, 2009, C. Exner, A. Kohl, M. Zaudig et al.

In this study, the authors began with the hypothesis that a high level of cognitive self-consciousness (increased tendency to focus attention on one's own thoughts and mental processes) might be the reason for certain memory deficits that have been reported in patients with OCD. Various measures of episodic memory (ability to recall or remember the specifics of a past experience or event) were conducted in 23 OCD patients and in 22 control subjects. Episodic memory was chosen because numerous studies have reported it to be the memory domain most affected in OCD patients. A self-report questionnaire was used to assess cognitive self-consciousness. Compared to the control group, OCD patients did display deficits of certain aspects of episodic memory, including reduced immediate and delayed recall of verbal materials. They also showed a higher level of cognitive self-consciousness compared to controls. The results of this study support the concept that divided attention and distraction caused by heightened cognitive self-consciousness is an underlying factor for the memory deficits that have been reported in patients with OCD.

Cognitive confidence in obsessive-compulsive disorder: distrusting perception, attention and memory

Behaviour Research and Therapy, 46(1):98-113, 2008, D. Hermans, U. Engelen, L. Grouwels et al.

The authors sought to replicate earlier work showing a relationship between OCD and distrust in memory. They wanted to build upon the assumption that this distrust in memory is caused in part by repeated checking that might lead to a deficit in perceptual processing and, as a result, a lessening in the vividness and details of recollections. More specifically, however, they set out to study more directly confidence in attention. In the final analysis they conclude that OCD sufferers do have less confidence in attention and memory than their nonclinical counterparts. They also observed that a lessening of confidence in attention and memory is related to repeated checking. They point to two clinical implications. First, they wonder if there might not be interventions aimed at building cognitive confidence that could effectively augment standard

treatments for OCD. Second, they suggest that most studies thus far have focused upon cognitive confidence and checking behavior, and they wonder if researchers shouldn't also explore the extent to which other behaviors such as doubting, contamination fears, and excessive rumination might also impact cognitive distrust.

How checking breeds doubt: Reduced performance in a simple working memory task

Behaviour Research and Therapy, 47(6):504-512, 2009, B. Harkin and K. Kessler

In this study, the authors address the idea that frequent checking might result in *reduced* memory certainty, vividness, and confidence, which is the opposite of what one might expect. 40 participants were given the Vancouver Obsessional Compulsive Inventory to establish checking tendencies. From this they were categorized as high or low with regard to checking behavior. Study participants were given two sets of memory tasks to perform. The first task was an easy, straightforward memory task. The second task introduced a misleading element intended to induce frustration and uncertainty, which could then lead to checking. The misleading element was felt to be analogous to an intrusive thought leading to uncertainty and repeated checking. The authors speculated that the misleading element would be more difficult to ignore in the high checker group and that certain memory functions are affected by repeated checking. The results of this study were inconclusive but do seem to indicate a greater level of detriment among high checkers, even though the misleading element in this study was found to induce a certain amount of checking in all participants. The authors believe that more research on this topic is necessary, but that enough evidence already exists to suggest that we might be able to augment OCD therapies with attention training and other programs aimed at shifting focus and managing intrusive thoughts.

RESEARCH NEWS**Research Participants Sought****Assessment of Perceptual Distortions in Individuals with Body Dysmorphic Disorder and Obsessive-Compulsive Disorder****Researchers:**

Jose Yaryura-Tobias, M.D.
Fugen Neziroglu, Ph.D.
Bio-Behavioral Institute
935 Northern Blvd., Suite 102
Great Neck, NY 11021

Researchers have hypothesized that many psychiatric disorders may affect individuals' perception. This notion has important implications for disorder etiology, maintenance, and treatment. Therefore, we are currently conducting a research study examining and comparing the visual perceptions of individuals with body dysmorphic disorder (BDD) and obsessive-compulsive disorder (OCD) to individuals without a psychiatric diagnosis.

Interested participants must be at least 18 years old to participate in this study. All participants will initially take part in a clinical interview to assess if they meet the study's guidelines. Individuals diagnosed with a psychotic disorder or a substance use disorder will be excluded.

If eligible, participants will then have two photographs taken of themselves. Participants will then complete a computer program, which will be comparing a variety of images, including the above-mentioned photographs. Upon completing the computer program, participants will be asked to fill out a series of questionnaires. All identities and responses will be kept strictly confidential. It is expected that the study will take about 4 to 6 hours to complete. Participants will be given a break and compensated with \$10.00 for lunch.

To participate in the study or for further information, please contact Melanie Santos at the Bio-Behavioral Institute at (516) 487-7116.

Study of Procedural Learning in OCD

The performance of patients with OCD symptoms while on either no medications or a stable medication regimen over time will be compared with a control group and with a group with major depression or other mood/anxiety disorders. We believe this will allow us to assess both the deficit, if any, of OCD participants in striatum-dependent procedural memory and how this deficit is or is not ameliorated by symptom reduction under standard pharmacotherapy.

Upon entry into the study and prior to initiation of pharmacotherapy, a thorough history will be taken, and a medical evaluation will be performed. Subjects will be evaluated by a combination of standardized measures, semi-structured diagnostic interviews, and standard methods of intelligence testing. Subjects will complete two baseline computer-based stratum-dependent learning tasks and some explicit learning evaluations. The baseline evaluations and intake screening take about 5-6 hours. As the study progresses, these tasks and some measures will be repeated and take approximately one additional hour each time.

Most patients who participate in this study do so as outpatients and the study requires them to come to our clinic in New Haven. There is some financial compensation for participating.

Anyone interested in more information should contact our nurse

manager, Suzanne Wasylink, at 203-974-7523.

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**.

Online Research Study

Does OCD interfere with your life? Are your primary obsessions and compulsions NOT focused on religion, spirituality, or morality?

If so, and you are 18 years of age or older, have been diagnosed with

OCD, and have access to the internet, you are eligible to participate in an anonymous research study.

The study will require you to spend about 20 minutes interacting with an investigational website, and answering questions about your OCD. We are interested in how non-scrupulous OCD (i.e., OCD not related to religion, spirituality, or morality) may relate to or impact your experience of spirituality or religion. No information will be recorded that would permit you to be identified.

To participate in this study, use your computer's browser to go to: <http://www.btassessment.com>

Lee Baer, Ph.D.
William E. Minichiello, Ed.D.
Jedidiah Siev, M.A.

Neuroimaging Study of OCD at Stanford, California

We are seeking subjects with Obsessive-Compulsive Disorder to participate in a research study of brain activity in OCD. The study is at Stanford University Medical Center and pays \$50 for a single MRI of the brain.

Eligibility:

- Right handed men and women ages 18-65 years old
- Have OCD predominantly with contamination / washing concerns
- Free of psychiatric medications, except for anti-depressants
- No history of neurological disorders (i.e. seizure, head trauma)
- No implanted metal in your body or tattoos near your head

If you are interested in participating in this study, please call Dr. White at (650) 725-5598 or email

mpwhite@stanford.edu. All calls are confidential. For general information regarding rights of research participants at Stanford, please call (650) 723-2641 or toll-free 1-866-680-2906. Thank you.

Need Help for OCD?

Does this sound like you?

- Thoughts that won't leave you alone?
- Repeating things over and over again?
- Washing your hands too much?
- Always checking the stove?

If you are currently on a psychiatric medication without full symptom relief and this sounds like you, you may qualify for a medication treatment study for no cost. Participants will receive either an FDA approved medication, a placebo (sugar) pill, or cognitive behavioral therapy. This study is open to men and women ages 18-70. Participation will last for 8-32 weeks. Call for a free screening: (860) 545-7039 or email: ADCresearch@harthosp.org.

Tell us about your rituals! A Web-Based Study from Washington University in St. Louis

We are asking you to describe in as much detail as possible the various rituals and routines that are part of your OCD symptoms. These may consist in mental routines (counting, adding), in special ways of washing oneself or cleaning objects, in hoarding objects, checking locks and car doors, etc. Although there are many clinical studies of OCD symptoms, the description of people's rituals is often very vague. It is important for researchers to understand exactly how these rituals

are organized. All this information is treated as anonymous confidential.

If you are interested in helping with this, all you have to do is answer a short questionnaire on the web, at this address:

<http://artsci.wustl.edu/~pboyer/RitualQuestForm.html>

For further information, you can contact Dr. Pascal Boyer at pboyer@wustl.edu.

Anonymous Online Survey of Personality Features (IRB# 5942)

Chance to win \$150 gift card to Target.com

Researchers at Columbia University/ NYSPI are seeking adults (age 18 and older) to complete an online survey about thoughts and behaviors related to personality styles. Participation is anonymous and may take up to 60 minutes. The information gathered will contribute to a better understanding of the nature of personality-related problems, leading to improved assessment and treatment. Participation is limited to once per person. For more information, click on this link: https://www.surveymonkey.com/s.aspx?sm=QmtdosuOkLMM81_2b7K7xDcw_3d_3d

If you would like to advertise your research study in this newsletter or on the OCF website, please send the text of your ad, as well as a copy of your IRB approval notice, to editor@ocfoundation.org. The subject should read: Research Participants Sought.

FROM THE AFFILIATES

Affiliate Updates

ILLINOIS

OCD Chicago's Spring-Summer Fundraiser

This year, compounded by the state of the nation's economy, the needs of those who suffer from OCD are escalating and their suffering is even more poignant. Join OCD Chicago in raising funds to help OCD sufferers regain control of their lives.

OCD Chicago is proud to announce the OCD Chicago Stimulus Raffle, or "Build Your Own Bailout." Each raffle ticket is \$50 and can be put towards your choice of prizes in three Ports of Call: Career & Investments, Personal Rejuvenation or The Isle of Pure Fun and Escape. Imaginative prizes in Career & Investments include an internship with MCIC, a Chicago firm specializing in demographic research for not-for-profits and an investment counseling session with a top Chicago financial advisor. You can also build your own Personal Rejuvenation bailout with a variety of massage and fitness prizes or, on the Isle of Pure Fun and Escape, take a chance at travel, hotel stays at the historic Belden Stratford, the in-town Seneca Hotel or bid on a fantastic Sommelier's Dinner for Six at the famed Kinzie Chophouse.

Raffle entries must be made by August 31, and the drawing will take place on September 8, 2009. If you would like to enter the raffle, call OCD Chicago at (773) 880-1635 or email info@ocdchicago.org.

There is no sweeter bailout than leaving mental illness behind.

MASSACHUSETTS

OCF of Greater Boston Has a Facebook Group!

The OCF of Greater Boston (OCF/GB) has created its own Facebook group so that you can connect directly with other members of the OCD community in Massachusetts and receive updates about upcoming OCF/GB activities. If you have a Facebook account, point your browser to <http://www.facebook.com/group.php?gid=77029112737> to read more about this group or to join today!

OCF of Greater Boston Announces Date for 2nd Annual Bike Ride and Fundraiser for OCD

When: Sunday Aug 30th, 2009*
Time: 10:30 AM
Where: Concord Middle School
 Sanborn Building
 835 Old Marlboro Road
 Concord, MA 01742

Ride Length: 40 miles

100% of the pledges you obtain will go directly to the Obsessive Compulsive Foundation to continue the critical research needed to help treat this condition. Volunteers are very much needed, so even if you don't ride your help will be just as important!

To learn more and to sign up for the ride, please visit:

<http://bike.meetup.com/207/calendar/9464143>

**Rain Date will be Sunday September 13th.*

PENNSYLVANIA

OC Foundation of Western PA's Spring Conference a Success!

On May 8, the OC Foundation of Western PA (OCF/WPA) co-sponsored a conference on "Effective Treatment of Obsessive Compulsive Disorder" with the Greater Pittsburgh Psychological Association (GPPA). A great effort was put forth by members of both local organizations to make the day a success.

Professionals seeking continuing education, as well as the general public, benefited from the material presented by our wonderful speakers. Dr. C. Alec Pollard began with an introduction to OCD. Dr. Robert Hudak then provided an overview of the medication used in the treatment of OCD. Dr. Pollard next discussed the use of CBT/ERP and the curriculum concluded with Kimberly Morrow, LCSW and Jeffrey Natalie, MSW discussing how to incorporate family members into the treatment process.

Most of the professionals who attended did not have a previous connection to the OCD community, which helped us to realize our goal of expanding the number of professionals in our community who are interested in treating individuals with OCD. It was rewarding to see therapists from the public mental health agencies attend the seminar as well. We were also happy to have Congressman Tim Murphy, Ph.D. in the audience. It always helps to have our elected officials aware of our community!

We thank the national foundation for their generous grant and the OCF staff for administrative support. We are so grateful to the speakers, GPPA, and all the volunteers who helped make the day a success. It was a rewarding experience for our group and we hope to repeat it annually.