

FROM THE FOUNDATION

Menninger Closes its Residential OCD Program

The Menninger Clinic in Houston, Texas elected to close its OCD Program, directed by Thröstur Björgvinsson, Ph.D., as of December 19, 2008. This program was one of only three residential OCD programs in the United States. Over the past 8 years, the Menninger OCD treatment team worked with over 500 patients and established a national and international reputation for effective and compassionate care. The OCD Program opened its doors in September 2000 in Topeka, Kansas and moved with the Menninger Clinic to Houston in 2003 as part of an affiliation with Baylor College of Medicine.

OCF staff spoke briefly with Dr. Björgvinsson, who commented that he was shocked by the decision. The former Menninger OCD team reports that the outpouring of support in the OCD community has been truly heartwarming and they thank everyone for their support. Due to the tremendous amount of encouragement that they have received to continue their work, this team has announced plans to open another facility in Houston, planned tentatively for Spring 2009. Additional information will be available on their new home page, www.houstonOCDprogram.com, which will be unveiled in the near future. If you want to offer support and help with the new clinic, please contact Dr. Björgvinsson at tbjorgvinsson@hotmail.com or the Peace of Mind Foundation (www.peaceofmind.com).

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The OCF's Behavior Therapy Institute: A One-of-a-Kind Continuing Education Opportunity for Mental Health Professionals

By Annette Perot, Ph.D.

Dr. Perot is a licensed psychologist with the Anxiety Disorders Treatment Center in Chapel Hill and Durham, North Carolina. Dr. Perot specializes in working with adults with anxiety disorders, including OCD and related disorders. In addition, she is currently president of the North Carolina Psychological Association and past co-chair of NCPA's Program/CE Committee. She can be reached at perot@email.unc.edu or (919) 942-0700.

When is the last time that you participated in a continuing education (CE) program and left saying, "that was the very best CE activity I've ever attended"? When is the last time that you felt so grateful for the excellent quality of a CE activity that you immediately joined the organization that held it?

The answer for me is October 2008, when I participated in the Obsessive Compulsive Foundation's 3-day Behavior Therapy Institute (BTI) held in Chapel Hill, NC. What you need to know is that I don't say this about every CE activity in which I participate. As a former co-chair of the CE/Program Committee for my state psychological association, I know a thing or two about what makes for a good quality training opportunity. And *(continued on p. 2)*

FROM THE FOUNDATION

(One of a Kind, continued)

the BTI is not your typical CE program.

What may be noteworthy as well is that I didn't come to the BTI as a novice in treating OCD. Having worked for the past 14 years in a practice specializing in anxiety disorders, I have worked with hundreds of adults with OCD and related disorders. It says volumes about the BTI that an experienced clinician like myself could leave with such a beneficial experience.

One of the positive aspects of the BTI is that it is limited to a small group of 30 professionals. I appreciate how this enabled us to get to know one another to a greater degree and begin to form collegial connections that I hope will continue to extend beyond that weekend. In addition, the 3-day format allowed time to cover not only the basics of OCD treatment, but also the more complex issues and challenges in working with this population. The balance of video footage and case examples, along with educational information, also really helped us to see the concepts come to life.

But wait, there's more! The third day of the BTI focused on small group case consultation, with each participant having prepared a case ahead of time. Rarely do we have such an opportunity to get individual feedback from an expert in the field; that opportunity extends beyond the BTI, as participants receive three additional phone consults with their group leader regarding their case following the BTI weekend.

Undoubtedly, my most convincing reason for enthusiasm is my experience of change following the BTI. After all, aside from a need to earn CEUs, isn't that what each of us is seeking anyway? It has been 2 months since the BTI and I continue to see ways in which I am working differently with my clients, whether it is in how I explain the model for treatment, assist in exposure work, or help a client work through stuck points in treatment. I only wish I had process research to empirically support my feelings. For now, you will just have to take my word for it. Hopefully, you will participate in a future BTI and experience it all for yourself. Trust me, you won't be disappointed!

2009 Behavior Therapy Institute (BTI) Dates Announced – Mark Your Calendars!



March 6, 7 & 8
St. Petersburg, Florida



June 26, 27 & 28
in North Chicago, Illinois

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 for each training!

**For more information regarding the Institute,
or to view our BTI Handbook and BTI Registration Forms:**

Visit the OC Foundation website at www.ocfoundation.org
or contact Michael Spigler at (617) 973-5801 or mospigler@ocfoundation.org

OCD NEWSLETTER

The OCD Newsletter is published by the Obsessive Compulsive Foundation, Inc.

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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.

This program is co-sponsored by IPPA, Inc. and the Obsessive Compulsive Foundation. IPPA, Inc. is approved by the American Psychological Association to sponsor continuing education for psychologists. IPPA, Inc. maintains responsibility for this program and its content. IPPA, Inc. is approved by the Department of Professional Regulation in Florida as a Continuing Education Provider for Licensed Clinical Social Workers, Marriage and Family Therapists, and Mental Health Counselors. Contact hours include up to 22.5 credit hours. Provider # BAP 260, Exp. 3/31/09. Application has been made to the National Board for Certified Counselors (SP-1515). Application has been made to the National Association of Social Workers (Provider #886371887).

Message from the President



Dear Friends,

These certainly are exciting times at the Obsessive Compulsive Foundation's national office in Boston! I am pleased to announce the arrival of the OCF's new Executive Director, Jeff Szymanski, Ph.D. Jeff received his Ph.D. in clinical psychology from Northern Illinois University in 1997 and for the past decade has specialized in the use of Cognitive Behavioral Therapy treatment models for

anxiety and depression. He worked for the past seven years at McLean Hospital's Obsessive Compulsive Disorder Institute, most recently as the Director of Psychological Services. Jeff has a deep commitment to effective treatments for OCD and, although he will not be working at the OCF in his role as a therapist, he looks forward to the new challenges of furthering the mission of the OCF.

I am also happy to announce that the OCF has hired three other permanent staff members. Michael Spigler, CHES, our new Program Director, joined the OCF in June and is responsible for the OCF's education and outreach programs, such as the Annual Conference, Behavior Therapy Institutes (BTIs), Speakers Bureau and website. He also works with the OCF's nine affiliates to help promote the organization's mission at a local and regional level.

Sae-Hee Williams, our Finance Manager, and Rebecca Cyr, our Administrative Assistant, were hired as temporary employees during the OCF's first days in Boston, and were hired as permanent staff members in October. Sae-Hee has been responsible for all financial aspects of the Foundation, including accounts payable and receivable, audit management, financial reporting, and budgeting. Rebecca, in addition to performing general administrative duties (hers is the friendly voice you are likely to encounter if you call the national office), is the OCD Newsletter's new Editor-in-Chief and assists Michael Spigler in the coordination of the BTIs and the Annual Conference.

For those of you who were lucky enough to meet any of these wonderful folks at the conference in Boston this past August, you know that the OCF is in extremely capable hands. I can't imagine a better group of people to take our organization forward in its mission. I'm sure you have already noticed positive changes to things like the website and the newsletter. In the months to come, I know their efforts will be even more apparent as we all work to educate, assist, and advocate for individuals with OCD and their families.

Diane Davey

President, OCF Board of Directors

OCF Bookstore Cleanout Sale Continues!

Thank you to all of you who have ordered books from us over the past few months! You have helped us to clear out desperately needed space for storage in our national office.



We still have a limited amount of books in stock, but we need your help to clear out the rest of them! Once we sell our remaining stock we will no longer sell books directly through our national office. To view a list of available books and to fill out an order form, please visit www.ocfoundation.org/bookstore. Please allow 1-2 weeks for the processing and delivery of all orders.

Do you want to buy a book that the OCF no longer has in stock? Don't worry!

The OCF maintains an extensive online book list, which contains the names of over 100 books on OCD and OC Spectrum Disorders, all of which are available for purchase at www.amazon.com. To view our book list, visit www.ocfoundation.org/ocd-oc-spectrum-disorders-book-list.html. We will also continue to sell books on-site during our three-day annual conferences every summer.

FROM THE FOUNDATION



Call for Presentations for the 16th Annual OCF Conference

August 7-9, 2009

Hyatt Regency Minneapolis • Minneapolis, Minnesota

What is the Annual OCF Conference?

The Annual OCF Conference is the only national meeting where people from all parts of the OCD Community come together to share knowledge, experience and expertise. The OCD Community is comprised of people with OCD or an OC Spectrum Disorder, their families and friends, and the mental health professionals who treat OCD or are conducting research in this field.

Topics of Interest

We have reviewed the evaluation forms from our 15th Annual Conference in 2008 and have compiled the following list of topic suggestions that may help you to develop your proposal. This list is not exclusive or exhaustive, so please feel free to submit a proposal on any topic that you feel would contribute to our 2009 Conference. Also, consider the type of presentation you would like to do including a symposium, panel, lecture, experiential/interactive format, and/or support group. A partial list of suggested topics includes:

General Issues about OCD

- In-depth examination of specific OCD symptoms/subtypes
 - Contamination/cleaning
 - Checking
 - Perfectionism
 - Intrusive violent/sexual thoughts
 - Emotional contamination
 - “Just right” obsessions
 - Scrupulosity
 - Hoarding
- OC Spectrum Disorders
 - Trichotillomania,
 - Body Dysmorphic Disorder (BDD)
 - Hypochondria
 - Compulsive Skin Picking
 - Tourette's/Tic Disorders
- Obsessive Compulsive Personality Disorder (OCPD)
- Co-occurring impulse control problems
- Other diagnostic issues
- OCD in different populations
 - Children and adolescents
 - Geriatric population
 - Individuals with a co-occurring physical disability
 - Adults
 - Minorities
- OCD in the classroom/issues with collaborating with schools
- Recovery and reentry into life, work, and school
- Relapse prevention
- Addressing treatment resistance
- Treatment refractory OCD
- Issues surrounding access to treatment
- Accessing private insurance, Medicare and Medicaid or coverage possibilities
- Legal issues and OCD

Family Issues

- Coping strategies for family members
- Family accommodation
- Parenting issues for individuals with OCD
- Dealing with adult children struggling with OCD
- Information on treatment modalities for parents

Treatment

- General Cognitive Behavioral Therapy (CBT) issues
 - Exposure and Response Prevention
 - Skills training
 - Acceptance and Commitment Therapy
 - Cognitive Therapy
 - Motivational interviewing
 - Dialectical Behavior Therapy adaptations
- CBT protocols for specific OCD symptoms/subtypes
- CBT in non-traditional settings (e.g., home based)
- CBT in different levels of care and modalities (e.g., residential, day program, group therapy, etc.)
- Educating the support system (friends, family, etc.)
- Medications for OCD and OC Spectrum Disorders
- Medication augmentation strategies
- Co-morbid conditions and their impact on treating OCD
- Neurosurgery options (e.g., deep brain stimulation)

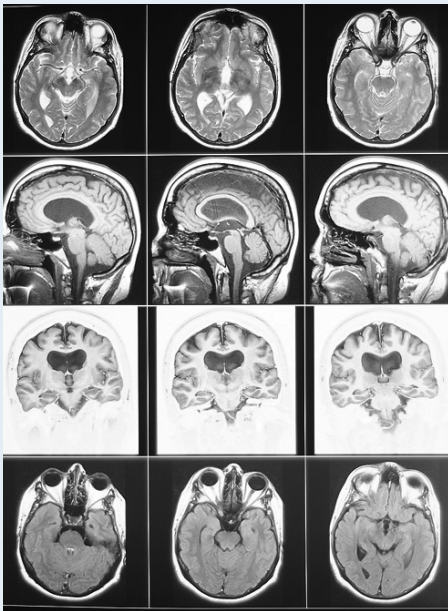
Research

- OCD and genetics
- OCD and neurobiology
- Research updates on treatment for different OCD symptoms/subtypes
- Reviews of recent treatment modality research (e.g., group therapy effectiveness for treating hoarders)

Please visit the OCF website at
<http://www.ocfoundation.org> in February 2009
 for submission guidelines and deadlines.
 Only electronic submissions
 will be accepted.

**The Obsessive Compulsive
Foundation
2009 Research Awards
Request for Proposals**

**Submission Period: December 1,
2008 – February 13, 2009 at 12pm**



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

The Foundation has been awarding research grants since 1994. Since then, it has funded over \$2,500,000 in OCD research.

For application guidelines and submission information, go to <http://grants.ocfoundation.org>.

If you have additional questions, please contact Jared Kant at ocfresearch@ocfoundation.org.

FROM THE FRONT LINES

A Proposal of Cooperative Therapy

by Jared Douglas Kant

"Do one thing every day that scares you." – Eleanor Roosevelt

Today has been a good day. Tonight has been a great night. But this hour has worn on my nerves. I've come home from a strange trip, literally and figuratively. I was just unpacking my bags and putting away the book I chose for the hotel when the feelings I had been neglecting in favor of great literature bubbled to the surface without warning. They are questions and statements about life and death that have been itching at me for the past few hours.

These feelings are coming to the surface because I have nowhere else to focus my attentional gaze. It is because I am torn and because I am tired. I am afraid of this experience ironically, because I have no compulsive behavior upon which to lean. I am at a deficit for distractions.

I see my other problems in front of me realistically, in all their beautiful simplicity. I have to hang a picture in my room. I have to put the picture in a frame. First, I have to decide where to put up the frame and then I can decide what picture to put up. These are simple, menial tasks. They have no real bearing on anything but my walls, which are inconsequential, even to me.

For so long my life has been governed by a set of arbitrary and meaningless rules. For those of you who are familiar with this feeling, I don't have to justify my frustration with the reality that these rules are insignificant to anyone but myself, or my anguish over the fact that these rules are irrational, or my resentment for the confusion others show me when I tell them that these rules must still be enforced and have deep meaning despite their apparently pointless nature.

These are the remnants of obsessive-compulsive disorder. It has been over a year since I penned my memoir and almost a year since it hit bookshelves. In the time since then, I've faced numerous obstacles, not the least of which has been reconciling the fact that now that I've made my experiences public, I must remember to follow advice that I have dispensed. There are few ironies crueller than the realization that you have to do the very things you're afraid of because you've told others to do likewise.

It has been a source of puzzlement for some of my recent interviewers. They ask what it's like to be cured. I tell them I'll get back to them when it happens. They ask the question differently and approach from an alternate angle: Am I, in my own words, now free from obsessive-compulsive disorder? I tell them yes. So in my own words, they want to know, have I been cured? Of course not, I explain. There is no known cure but vigilance. Vigilance and strength are what will get you through the bumps in the road. I'm lucky though – I get a whole readership to watch me grow.

(continued on p. 6)

FROM THE FRONT LINES

(Cooperative Therapy, continued)

Some of you are going through it alone; fighting the fight each day without anyone the wiser should you slip and fall. Somehow this seems unfair, and I want to make a proposal to correct this imbalance. I propose that we aim, as a community, to help each other stick to our goals.

So here it is: I've decided to strike a deal with you, the reader. I'll put up this picture frame; I'll put the nail to the drywall and pound it in once. I'll leave it there until gravity brings it crashing down and I'll sit with the uncertainty because that's what I would tell each and every one of you to do if only you were to ask me. So here's what I ask you to do in return:

Pick one thing that terrifies you – something from your own fear hierarchy, something small that you intend to conquer between now and the conference in August – and write it down on an index card or a piece of paper. Mail it to:

O.C. Foundation
c/o Jared Kant
P.O. Box 961029
Boston, MA 02196

Remember: this is a group effort. It is my hope that we can collect enough cards to cover an entire wall at the site of the 16th Annual OCF Conference in Minneapolis, MN this August.

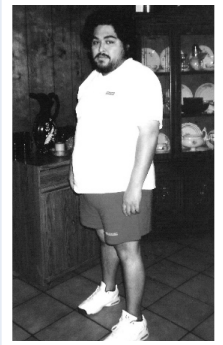
We'll sit through this one fear together and after the anxiety has settled and we've all conquered a little bit of OCD separately, we can come together and see how much fear we can overcome as a community. From the seven or so years I've been going to OCF conferences and seeing people transform from "without hope" to "without limits," I have every bit of confidence that what can be accomplished when we work together will be limitless.

So pick up a pen, write down your fears and join me. Welcome to recovery.

My Victory over OCD

by Rick Lozano

I have had OCD for 11 years. The first eight years were truly miserable. I couldn't figure out what exactly was wrong, but I knew that some of my behavior was pretty strange. I started pulling out my hair, biting my nails, triple-checking things, and even avoiding certain things. I thought I was just going through a period of nervousness, so I ignored it. That turned out to be my biggest mistake because I let the situation escalate to a level that became almost unbearable.



2004 at my worst

As time passed, my OCD got so severe that I had to ask a friend for help because I couldn't handle it alone anymore. It was taking me 3 hours to take a shower, 2 hours to get dressed, 1 hour to shave, and 1 hour to check my car. Eventually I stopped driving, I stopped shaving, I stopped using the phone, and I stopped showering unless it was absolutely necessary. I started avoiding people, places, and situations. Whenever I tried to do something I would get extremely anxious, so I decided to stop doing things. I stopped functioning altogether.

I lost several good jobs, and my financial situation was horrible. I applied for social security benefits and was denied three times because my condition was not considered to be severe enough, even though I had documentation from several doctors that indicated how critical my condition was. I was treated by 3 psychologists, 5 psychiatrists, a psychotherapist, and even a hypnotherapist. I was given all sorts of medications, but nothing worked.

I now know that some of the doctors that I saw at that time did not know how to help me adequately. They would just ask me a few questions, listen to me for a couple of minutes, and send me away with a little piece of paper to take to the pharmacy. I was given no answers or solutions; just pills.

One night in 2003 I began to consider ending my life. That evening I ended up at the El Paso Psychiatric Center, where I was kept for the next 3 days. That was the darkest period of my entire life. Finally, in the beginning of 2004 I got tired of the doctors who couldn't help me, of the medicine that wasn't doing anything, of an illness that was only getting worse. I made the decision to control my OCD no matter what. I didn't want to lose my family, and I didn't want to spend the

rest of my life in bed just waiting to die. I had almost lost everything because of OCD, and I was determined that I would not go down without a fight.



Present

I began to do research, and I read everything that had to do with OCD. I studied and analyzed my behavior and began looking for patterns. I made major lifestyle changes: I started exercising, and I changed my eating and sleeping habits.

One of the most dramatic realizations for me during that time was how important it is to find a good therapist with a lot of OCD knowledge to help you with your recovery. If you get an aggressive therapist, you might feel like he/she doesn't understand what you're going through. If you get a passive therapist, you might feel like he/she doesn't have enough OCD knowledge to truly help. An ideal candidate would be an assertive therapist who has the ability to answer your questions, as well as the humility to say, "I don't know" when he/she doesn't have an answer. The best OCD therapist to have is one that gives you solutions, answers, techniques, and a good strategy that will help you get back in control of your life.

Finally, after several months of extremely hard work, I began to outpace my OCD; it no longer made decisions for me. There had been a time when I thought it would be impossible to rise above my OCD; I thought I would go "crazy," lose my family, and end up in a psychiatric hospital forever. I had been wrong. In the past, OCD controlled me; now I control it.

I used to think that having OCD was a curse, but I have discovered that it was really a blessing in disguise. Having OCD has forced me to deal with issues that I had avoided all of my life. I have been able to discover who I was and who I am destined to become. OCD might interrupt me, but it can't stop me anymore. My life is now better than it ever was; now I love my life!

Paralyzed

By Larry Bolger

I was diagnosed with OCD on May 5th 1989. The night before, I had been studying for two exams that I needed to pass in order to graduate. Before I knew it, it was 3 a.m. and I was still on the first page studying for my first exam. I was stuck in an endless cycle, and I knew I needed help. The next morning when the crisis center opened at Penn State University, I went in to see a psychologist. After describing to her what I had been doing, she pulled out the DSM-III and read me the definition of obsessive-compulsive disorder. She described exactly what I had been doing! First I was dumbfounded, but then I felt validated by the diagnosis. I did not understand the magnitude of the disorder at the time. I was both exhausted and relieved. This was my first victory in my fight against OCD: I now knew what it was.

Unfortunately, soon after my initial diagnosis I began partying with my fraternity brothers. Even after I left Penn State I continued partying. In the midst of this however, I was able to find a psychologist and psychiatrist from the county mental health department and, to my surprise, they were both knowledgeable in OCD. The psychiatrist put me on Prozac and the psychologist began to work with me on Exposure and Response Prevention (ERP) techniques. Unfortunately, alcohol and drugs counteracted any effects that the Prozac would have had on my OCD, and I rarely carried out my part of my ERP homework assignments. As a result, the services I was receiving had little effect on me, and I continued to master ways of hiding my OCD. I was suffering every day, and I found myself stuck in a situation from which I couldn't break free. Looking back, that should have been a turning point in my life; I regret the decisions I made in those days.

Then on one fateful day in 1990, as a result of a diving accident I broke my neck at the C5C6 spinal column, which rendered me paralyzed from the chest down. I had what some might think is a strange reaction to being paralyzed: I felt that it was important that this had happened to me. For the first time, it really made me confront my OCD and it got me to stop my self-destructive drinking and drugging. I began to recognize that I was more paralyzed from my OCD than from the paralysis of

(continued on p. 8)

FROM THE FRONT LINES

(Paralyzed, continued)

my body. However, with my newfound awareness, I was put face to face with my anxiety about dirt being on the floor, being preoccupied with not being able to keep things symmetrical and in order, and on and on. Because I couldn't resort to some of my old physical rituals, I was acutely experiencing more anxiety and was all of sudden doing ERP whether I liked it or not!

As I started to deal with the increased intensity of my OCD, I also began the long and agonizing process of rehabilitation. Looking back, I think I was completely overwhelmed with trying to recover from my physical injury and trying to deal with my OCD and depression. My difficulties increased as I was prescribed medications that were inappropriate for treating OCD symptoms. I had difficulty sleeping, and would yell and scream and carry on because of my anxiety. I was eventually admitted to a psychiatric institute, and later to another rehabilitation facility, where a psychiatrist restarted me on Prozac, which actually helped me a lot. Soon afterward, I started seeing a new psychologist and things started to look better and brighter. Don't get me wrong – my OCD was still dominating my life, but positive things started happening. And don't think for a second that any of this was easy; on the contrary, I was still anxiety ridden and I had started to perform mental rituals while continuing to perform every physical ritual that I was able to do. My behavior began to be easier to recognize and to control. I soon came to recognize this familiar cycle of ups and downs in my struggle to get my OCD under control.

My psychologist helped me develop coping skills and gave me the hope that I could lead a normal life. I began attending an OCD support group and finished my bachelor's degree at Penn State University. I began studying for the Master's entrance exam, and I was accepted to the Master's program in Rehabilitation Counseling at Edinboro University. Pure perseverance, diligence and an understanding from the school faculty, along with a handful of attendants, helped me make it through grad school. By the fall of 1999 I had started an internship, and had moved into a new apartment. After I completed my master's project, which took me a year to finish, I graduated with a 4.0 GPA.

After this period of success and accomplishment, I was daunted by a return of my symptoms. Since I have become a quadriplegic, the OCD "Monster" has adapted to my situation, which is to say that the majority of my OCD now is expressed as mental rituals, such as perfectionism and checking. It would take me hours to write a paragraph. Performing these rituals is very exhausting. Some days I would do absolutely nothing but perform my rituals. Those were long, dark days; I felt useless and trapped. I decided to take some time off before starting to look for a job, but I procrastinated until it came to a point where I was so caught up in my mental rituals that I felt I was unable to hold down a job. My self-confidence plummeted as my rituals became worse. I felt like I didn't have any clear goals or hope anymore.

Eventually I attended an intensive outpatient OCD clinic in Pennsylvania to help get control of my life again. Although the program was helpful, it was sometimes difficult to trigger my OCD. This past year, I feel like I am back in the game and working on some goals. I had been sidelined for many years, but now one of my current aspirations is to educate others about OCD. I have recently spoken to medical students, psychology classes, and other health professionals, and I'm interested in leading support group in my area. I plan to become more active in the community, and have volunteered for some community groups. I have been attending physical therapy for approximately three years, which has been positive because it allows me to socialize and the physical activity somewhat takes my mind off my OCD. The future is starting to look somewhat brighter.

I wanted to write this article to express the ongoing struggle and successes associated with one's battle with OCD. My wish is that this article will give hope to others who may suffer from dual-diagnosed physical and OCD disabilities and the challenges that are unique to us. I would be interested in hearing from others who may have similar problems. If you would like to get in touch with me, you can email me at lipc5c62@aol.com.

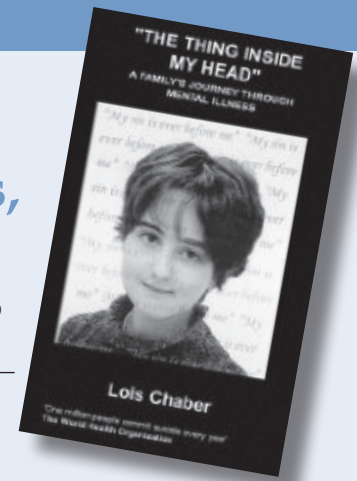
If you would like to submit your creative writing, personal story or artwork relating to your OCD experience, please email your submission to editor@ocfoundation.org.

The subject should read: From the Front Lines.

Book Review: The Thing Inside my Head: A Family's Journey through Mental Illness, by Lois Chaber

Reviewed by S. Evelyn Stewart, M.D.

Dr. Stewart is a clinical and research psychiatrist at Massachusetts General Hospital and the OCD Institute at McLean Hospital. She is also a member of the OCF's Scientific Advisory Board.



This book provides a non-fiction account of a young woman named Sybil Macindoe, written posthumously by her mother. The book is written as a compilation of narratives and photos written and collected by Sybil herself, her mother, her sister Molly, and mental health professionals involved in her treatment for obsessive-compulsive disorder (OCD) and anorexia nervosa in the 1980's-90's. This sad, moving collection walks the reader through the helplessness and confusion that families often experience in the face of undiagnosed and misunderstood mental illness through to Sybil's eventual suicide. The reader's emotions are intensified by the fact that Sybil does not realize for some time that her illness has a name – obsessive-compulsive disorder-- a treatable disease. Too late she begins to recognize some of her thoughts and behaviors as symptoms of OCD and one is left to wonder whether a happier outcome might have occurred with current day treatment approaches, or with earlier diagnosis and increased public awareness of this disorder.

Of note, the appearance of Sybil's OCD is very severe in comparison to most cases, and is complicated by a co-morbid eating disorder, anorexia nervosa. For example, although cognitive-behavioral therapy and medications are the 'gold standards' of treatment, only a minority of OCD-affected individuals require hospitalization as was the case for Sybil. Moreover, reported suicide rates in OCD alone are not as substantially elevated as for some other illnesses such as bipolar disorder, body dysmorphic disorder or schizophrenia.

However, this book is full of insightful pearls of wisdom and teaching points for those dealing with OCD, whether in themselves, among loved ones, or when working with patients/clients. As demonstrated in the early treatment experiences of Sybil's family, clinicians are often unfamiliar with the varied symptoms of OCD, which can delay its diagnosis and management and occasionally lead to inappropriate blame. In addition, observing the behaviors of individuals with OCD can be very deceiving, since behaviors do not necessarily reflect associated internal emotional struggles that take place within individuals' minds. Illustrating this, an excerpt from Sybil's writings sharply contrasts her external and internal states during a prolonged period of muteness. During this time she was being fed through a nasogastric tube, considered to be catatonic, and was appeared to be mentally disconnected from the world around her. In contrast, her subsequent journal entry reflects her awareness of this external world and her awareness of her losing struggle to fight the "voice that she thought was God (her OCD)" by stopping her continuous rituals.

The tragic outcome of Sybil's life story is not the conclusion to this book. Rather, the final component of this family's 'journey through mental illness' is spent in reconciling their experiences to create this work that aims to guide others in their own struggles. Lois Chaber explores the potential origins, exacerbating factors, treatment attempts and potential alternatives that may have resulted in a different outcome. In Sybil's mother's words, "we are confident she would have wanted sufferers, families and care givers, among many others, to learn and benefit from this cautionary tale....she wanted to touch people's hearts not only with her sufferings but also with her brave struggles against them."

I recommend this book to clinicians and others wishing to gain a deeper, intimate understanding of some of the experiences faced by those suffering with severe OCD. I would balance the sorrow in Sybil's story with optimism, arising from the knowledge that books and works like these have and will continue to raise public awareness for OCD. This book in turn has supported research efforts to develop improved treatments aiming towards a cure. I applaud the courage that Sybil's mother demonstrated in sharing her family's story, and would encourage parents reading this to contribute to this cause by becoming involved in OC Foundation activities.

FROM THE FRONT LINES

Book Review: The OCD Answer Book, by Patrick McGrath, Ph.D.

Reviewed by Eric Storch, Ph.D.

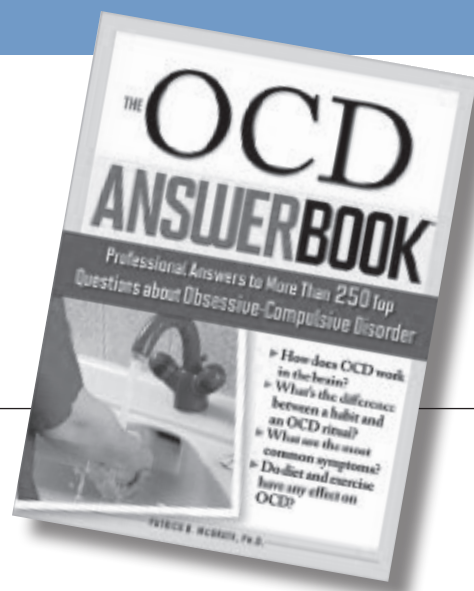
Dr. Storch is the Director of the University of South Florida Child and Adult OCD Treatment Program in St. Petersburg, FL. He is also a member of the OCF's Scientific Advisory Board.

Clinicians require a book to recommend to their patients with obsessive-compulsive disorder (OCD) to augment the education that takes place during treatment and to address common questions that may arise. Similarly, people with OCD require a text that can clarify the many questions that come with having the disorder: What types of treatments are available (and work)? How do I discuss the condition with my significant other?

How can I understand the nature of the disorder? Without question, Dr. Patrick McGrath's *The OCD Answer Book* answers the need for such a book. It is a focused, informative, and easy-to-read book that provides accurate answers to over 250 common questions related to OCD.

Quite impressively, *The OCD Answer Book* covers a wide variety of subject matter. Throughout its eleven chapters, this book defines and discusses OCD and its core features, its etiology, and the types of effective treatment for it, and explains how to overcome obstacles for seeking and/or accessing appropriate care. Each chapter is organized in an easy to follow fashion with the questions to be covered listed on the chapter face page. Questions are presented thereafter in a bolded font with the corresponding answer underneath. Dr. McGrath's expertise is clear throughout, as answers to these common questions are provided in a rational, evidence-based manner that is also entertaining and pleasant to read. In addition to the primary chapters, the following four Appendices are included that people with OCD will likely find helpful: an Obsession Challenge worksheet, a form to track exposure completion, a template for creating a fear hierarchy, and finally, a form to track and challenge core beliefs.

Taken together, this text has many features that make it a helpful supplement when working with people with OCD. Clinicians would be well off in advising their patients to read this book given its breadth of coverage, objective and data-driven approach to covering the requisite information, as well as its overall readability. People with OCD – whether in treatment or just interested in learning more about their condition – will find this book thorough, helpful, and able to address many of their questions. The text also provides a listing of helpful resources for people to seek additional information should it not be covered. For those who are considering treatment, *The OCD Answer Book* will teach about the proven therapies available and help the person navigate through many of the pitfalls that may occur when seeking help. Significant others of a person with OCD will also find such a text helpful in answering many questions they may have regarding the disorder, and in particular, how to interact with their loved one who has the disorder.



The OCF would like to restart a "Youth Corner" section in the OCD Newsletter. If you are 18 or younger and would like to submit your personal story, creative writing, or artwork relating to your OCD experience, please email your submission to editor@ocfoundation.org.

The subject should read: Youth Corner.

THE THERAPY COMMUNITY

Couples Therapy for OCD: When OCD Becomes A Family Affair

By Jonathan S. Abramowitz, Ph.D., ABPP

Dr. Abramowitz is the Director of the Anxiety and Stress Disorders Clinic at the University of North Carolina (UNC) at Chapel Hill. He is also a member of the OCF's Scientific Advisory Board.

Joshua's Story

Joshua's problems with obsessive thoughts about violence began when he was a teenager, but when he and his wife Rachel brought their firstborn daughter Amy home from the hospital, things worsened dramatically. He began having intrusive thoughts of harming his beloved infant on a daily basis. Thoughts about punching the baby, dropping her down the steps, and even putting her in the microwave came to mind and created an enormous amount of distress. Of course, Joshua loved his baby with all his heart and never acted on any of these thoughts. They were the exact opposite of his usual personality. Still, Joshua believed he was an awful parent for having these thoughts and was at a loss for what to do. He couldn't tell anyone about the obsessions – they'd surely lock him up! – so he avoided having anything to do with his baby. This was a disappointment to Rachel, who didn't know what was happening, and soon resented that she was changing all the diapers, doing all the feedings, and giving all the baths without any help from Joshua. Joshua and Rachel's relationship went downhill. They had endless arguments over caring for Amy, and the level of stress in their relationship became very high. This added stress, of course, exacerbated Joshua's OCD symptoms. Joshua even moved in with his parents for a short time.

Mary's Story

Mary, who had suffered from OCD since childhood, married her high school sweetheart Tom at the age of 21. Her obsessions focused on the fear of contamination from germs from strangers. She was specifically afraid of contracting the AIDS virus. Her compulsive rituals included washing, showering, and changing her clothes whenever she thought that she might have been exposed to HIV, and she involved Tom in many rituals as well. For example, she would ask Tom for reassurance about the chances of getting AIDS from doing activities such as touching a doorknob or using a public restroom. Tom helped Mary wash off all mail and groceries that were brought into the house. At times, Mary would call Tom in the middle of the day to leave his job and come calm her down. Tom complied willingly with Mary's compulsive urges – after all, he couldn't stand to see Mary suffer. What if she had a "nervous breakdown" or something? He ended up doing just about everything possible to prevent Mary from ever having to suffer from obsessional fear. When Tom and Mary came to our clinic for therapy, Tom was performing compulsive rituals for Mary almost as often as Mary was performing them herself.

OCD and Couples

Both Joshua's and Mary's stories show how OCD can negatively impact close relationships such as marriages and partnerships.

Joshua's story is rather straightforward: His symptoms led directly to avoidance, which angered his wife and led to arguments and havoc in his relationship. But Mary's story is a little less straightforward. She and her husband Tom rarely had arguments over OCD. Tom showed his love for Mary by keeping her as anxiety-free as possible. But OCD had become a part of their relationship. Their life as a couple was centered on helping Mary complete her rituals and avoid being in distress. It was like OCD was another family member. On the surface, this kind of caretaking might seem like a wonderful way for Tom to show his love for Mary, but the fact was that that this pattern only made Mary's problems with OCD worse. As much as Tom hoped that Mary could get over her problems, and as much as he reassured her that she was not in any danger from getting AIDS, Mary continued to suffer. Ironically, Tom's accommodation of Mary's symptoms played a large role in why Mary continued to suffer with OCD.

Treating OCD When it Affects Relationships

Cognitive behavior therapy (CBT) using the techniques of exposure and response prevention (ERP) is the most effective treatment available for OCD – it often leads to a 60% to 70% reduction in obsessions and compulsions. But unfortunately, most CBT work is done with only the OCD sufferer,

(continued on p. 12)

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(Couples Therapy continued)

leaving out other family members who might, in one way or another, influence the course of OCD symptoms. This is particularly the case for people with OCD who are in close relationships. For this reason, at the University of North Carolina's Anxiety and Stress Disorders Clinic, we have developed and are currently testing the effects of a CBT treatment that is conducted as a couples-based therapy. The person suffering with OCD attends all of the 16 therapy sessions along with his or her spouse or partner, and the couple learns to implement the CBT skills (primarily ERP techniques) together. We also teach couples how to improve their communication and problem-solving skills so that arguments like the ones that Rachel and Joshua were having could be more easily resolved. Recognizing and stopping accommodation patterns, as in Mary and Tom's example, are also emphasized in our therapy. Both partners take responsibility for working hard to help the person with OCD overcome his or her problems. We are hoping to find that this treatment program improves upon the long-term outcome for individuals with OCD, especially those who are in close relationships. We also expect that it will lead to improvements in relationship satisfaction.

Our Couples-Based OCD Treatment Program

Our treatment program has a number of similarities to individual therapy for OCD. During the first few sessions, the therapist learns all about the patient's problems with OCD, including situations that trigger obsessional thoughts and anxiety, patterns of avoidance behavior, and patterns

of compulsive rituals. Time is also spent learning about the way that the couple interacts around the OCD symptoms. For example, how does OCD play a role in the relationship? How do the partners cope when the person with OCD becomes very anxious? The therapist uses all of this information to formulate a treatment plan for the rest of therapy. This plan is discussed with the couple so that both partners understand OCD and how a couples-based approach to ERP is a sensible way to reduce its symptoms.

Starting at about the fourth therapy session, the couple begins learning and practicing how to implement partner-assisted ERP. This means teaching the partner without OCD how to help the OCD sufferer face obsessional fears rather than avoid them and to resist performing compulsive rituals rather than giving in; the partner without OCD is also taught how to resist assisting the OCD sufferer with such rituals. As in individual exposure therapy, a treatment hierarchy is developed that includes a list of feared situations that the person with OCD should practice confronting, with his or her spouse or partner present. The therapist assists the couple with conducting ERP during their session, and then assigns exposure homework for the couple to practice on their own. Time is also spent teaching the couple strategies for getting through high levels of stress and anxiety, rather than bailing out when the going gets tough. Remember: Anxiety is a temporary thing; it doesn't last forever when you do exposure therapy.

After several ERP sessions, the therapist begins to focus on couple-related issues such as

improving communication with one another and teaching the partners to share their thoughts and feelings honestly and without arguing. An important part of these couple-focused sessions is helping the partners to recognize and change their patterns of accommodation, such as those that were present in Mary's story. Between these sessions the couple continues to work on their own ERP exercises, because this is the main ingredient necessary for getting over OCD. Time in the session is also used to plan activities that the couple can do for fun outside of OCD.

Some Closing Words

Our treatment program involves a total of 16 therapy sessions, although couples work very hard between sessions practicing ERP and relationship enhancement skills so that they have an "intensive" therapy experience. The results of our initial study have been encouraging so far: We have observed an average of 50% reduction in OCD symptoms, and substantial improvements in relationship functioning and relationship satisfaction. As difficult as it might be to find therapists who are well-trained to provide good CBT (specifically ERP techniques), it is even harder to find therapists with expertise in both OCD and couples therapy. Thus, once our study has ended, we will work hard to disseminate our treatment program through trainings and workshops so that more therapists can incorporate couples work into CBT for OCD. As a long-time practitioner of individual CBT, I am now convinced that it makes sense to consider incorporating the spouses or partners of OCD patients into therapy.

Crossing Borders with Exposure and Response Prevention

By Jason Elias, Ph.D.

Dr. Elias is a licensed clinical psychologist who specializes in the treatment of obsessive-compulsive disorder and other anxiety disorders. He currently works as a Behavior Therapist at the Obsessive Compulsive Disorder Institute at McLean Hospital. He is also a principal investigator on research projects and an Instructor in Psychology for Harvard Medical School, providing supervision for psychology trainees in cognitive behavior therapy. Dr. Elias maintains a private practice in Belmont, Massachusetts where he provides individual therapy for people with anxiety disorders. You can contact Dr. Elias at jelias@mclean.harvard.edu.

Identifying the Problem: Barriers to Accessing Effective Treatment

The Obsessive Compulsive Foundation has been a resource for individuals with OCD, their families, and practitioners for over 20 years. The mere fact that you are reading this newsletter is evidence that the OCF's mission to disseminate information about OCD and its treatment has been a success. The founders and all those who have been involved with the OCF over the years deserve our thanks, and I'd like to encourage readers to show their thanks by seizing opportunities to further the mission. For each person who reads this, there are thousands of people who might benefit from treatment, but do not know it or have access to it.

This reality hit me hard last year during an exchange of emails with a psychologist from El Salvador – Dr. Daniel Guttfreund – who was seeking training in Exposure and Response Prevention (ERP). Dr. Guttfreund explained that exposure therapy is not available in El Salvador, which meant that he could not refer his OCD patients to any specialists. His solution has been to recommend anxiety clinics in the States, while learning as much as he could about the therapy himself. In the US, I give presentations educating people about OCD and ERP to inform them of the options available to them. In areas far from major cities and universities, gaining access to treatment is still a problem – but imagine having no option but to leave your country to get treatment; such is the case in Central America.

Addressing the Problem

Dr. Guttfreund had offered a unique opportunity, so I decided to team up with him and bring exposure therapy to El Salvador. We started by having Dr. Guttfreund come to Massachusetts for a three-day intensive training on exposure therapy for OCD. During these three days, we worked together for four hours each day so that he could understand the basics. After this initial training, I accompanied Dr. Guttfreund to El Salvador to continue his training as well as to try to make an even bigger impact by working with key members of the community, specifically those who train future therapists. In doing so, it is our hope that our investment of time and energy will become a self-sustaining system where each psychologist we train will result in dozens more who will learn the exposure techniques from them. During this phase of our venture, we spoke with local media and I gave public lectures about OCD and ERP.

I have been able to continue supervision with Dr. Guttfreund and other therapists in El Salvador who are interested in learning more about OCD and ERP by utilizing free software that allows people to talk over the internet (e.g., skype). It is very inexpensive compared to talking over the phone and it allows us to conference people in easily. The only cost is the internet connection itself and the headset or microphone that each person uses. Perhaps most importantly, we can see one another by using inexpensive webcams, which allows me to model ERPs and to observe body language and facial expressions.

We are now embarking on the next phase by presenting a seminar at one of the local training programs in El Salvador in January 2009. This visit will also be devoted to the first round of trainings with two faculty members at a local university. We will continue our supervision over the internet, and I will return periodically to do more seminars and meetings and to set up medication seminars for local psychiatrists. Our ultimate goal is to have a specialty clinic devoted to training therapists and treating individuals with OCD and other anxiety disorders. Once the clinic is established in San Salvador, we hope to disseminate the treatment throughout Central America.

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(Crossing Borders continued)

Other Barriers to Effective Treatment

An unexpected benefit of this process also caught my attention. I have supervised novice therapists learning exposure therapy, but never an experienced psychologist like Dr. Gutfreund. I was struck by how much my supervision helped both of us in understanding the process. During one of our training sessions, I remember explaining briefly the importance of modeling ERP for patients early on in therapy. This seemed like a simple enough idea and we proceeded with an example. In order to illustrate how one would conduct a “checking” exposure, I casually pulled a few items from my wallet and tossed them to the floor of the hotel lobby and walked away. I thought Daniel was going to choke when I suggested he follow suit. It turned out that he felt very anxious about trying this. This led to a very productive discussion of learning your own limits and how to break through the walls of convention to find freedom on the other side. After all, it's easier to help others if you have tried to put yourself in their shoes. It also reminded me of my first experience with ERP and how important supervision is for success:

In my second year of graduate school, I was assigned to work with a woman in her 70's with severe OCD. I was incredibly nervous to be conducting exposure therapy for the first time, and I remember thinking, “How can I torture this lovely person by asking her not to shower for days on end and drive her car without mirrors?” I also experienced some doubt that I'd be able to make an impact on 40 years of OCD. She had been consumed by checking rituals for the majority of her life but never knew there was a name for her problem. A family member convinced her to schedule an intake appointment at our anxiety clinic after hearing a lecture about OCD. (As an aside: Consider giving one of those talks if you haven't already! You could change someone's life forever.) In a matter of weeks, we were already seeing changes in longstanding patterns of anxiety, and my client was experiencing more freedom. I was inspired by her courage and amazed by the power of ERP to loosen OCD's grip. This experience is a large part of why I chose to specialize in anxiety disorders and OCD.

I'd like to take credit for my early success, but I must admit that my client improved through her own hard work in addition to the expert supervision of my work by Dr. Nader Amir. I am convinced that without his guidance I would have succumbed to one of the many barriers that interfere in therapists learning ERP. Cook, Schnurr, and Foa (2004) describe some of the issues related to disseminating exposure therapy for PTSD, but I believe many of the same hurdles exist for disseminating ERP for OCD. I have included some of the potential barriers for practitioners summarized in their article:

- Lack of training/confidence in ERP
- Past failures with ERP
- Belief that ERP could directly harm the patient (emotionally/physically)
- Concern that the therapist “forces” the patient to confront fears
- Low emotion tolerance
- Belief that ERP could worsen symptoms
- Do not agree/understand rationale for ERP
- ERP will be harmful to the therapeutic relationship

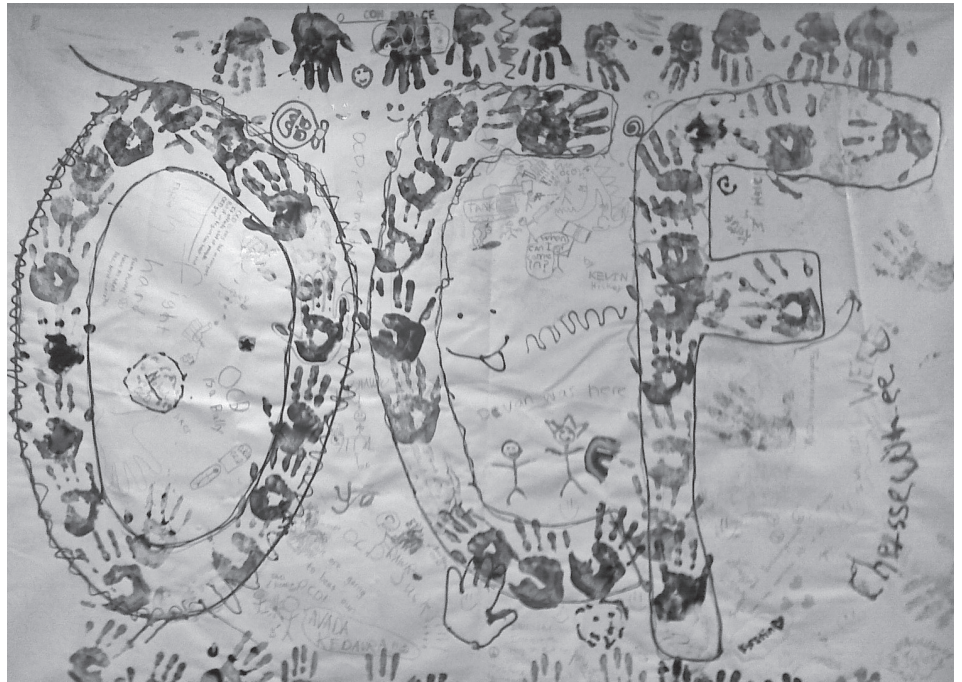
Therapists are not accustomed to asking clients to engage in behaviors that will provoke anxiety, and they find it difficult to recommend ERP even with a sound rationale. When clients experience a spike in anxiety during session, therapists may themselves feel uncomfortable and abandon the ERP before habituation has occurred. This results in treatment failures and reinforces avoidance behaviors. Both the client and therapist are left doubting the treatment.

Cook et al. (2004) does a nice job of providing some solutions to these barriers as well as others not listed above. Dr. Amir helped me identify and work through several of these barriers in my first case and gave me the confidence to try again and to maintain focus on the ERP, especially at the moment when I might want to pull back. I probably would have decided on a different specialty were it not for his supervision. I thought about this quite a bit during my supervision with Dr. Gutfreund, and I really admire his commitment to learning something outside his comfort zone in order to help the people of his country.

Concluding Thoughts

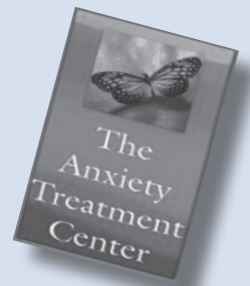
I imagine most of you reading this article know a lot about OCD and exposure therapy because you are members of the OCF. If you are just learning about OCD, you will find that the OCF has valuable information in several languages on their website to help you learn more and identify specialists in your area. Please help OCF carry on its mission to educate the public about OCD by telling someone about the organization or something you have learned in this edition of the newsletter.

Cook, J., Schnurr, P., & Foa, E. (2004). *Bridging the gap between posttraumatic stress disorder research and clinical practice: The example of exposure therapy. Psychotherapy: Theory, Research, Practice, Training, 41 (4), 374-387.*



OCF mural made by yong conference attendees in the art therapy room at the 2008 Annual Conference in Boston

Unique Opportunity offered by The Anxiety Treatment Center of Sacramento



The Anxiety Treatment Center of Sacramento is offering a scholarship which includes up to four weeks of Intensive Outpatient Treatment. This opportunity is available to individuals who have been diagnosed with a primary diagnosis of Obsessive Compulsive Disorder, and to those without medical insurance. Applicants may be of any age, and must be experiencing a moderate to severe level of symptomology who can benefit from this level of care. The award recipient will have the opportunity to reside in Serenity House, the program's residential housing facility offered to those enrolled in the Intensive Program. Family members will also have the option to participate in the treatment process, helping them to learn ways in which they can better understand and support their loved one.

The Anxiety Treatment Center is a full-service outpatient clinic that offers individual, group, and family therapy, in addition to their Intensive Outpatient Treatment Program. In operation since November 2005, this program has successfully treated individuals suffering from OCD and other anxiety related conditions through their specialization in Cognitive Behavior Therapy and Exposure and Response Prevention Techniques. This scholarship will support the center's mission to reach out to those who may otherwise not have had the resources for this level of care.

For an application, please contact Dr. Robin Zasio, Psy.D. at drrobin@sierrabg.com, or by phone at (916) 366-0647. For more information about The Anxiety Treatment Center of Sacramento or this scholarship opportunity, visit www.AnxietyTreatmentExperts.com.

Deadline for submission is March 15, 2009. The scholarship award recipient will be notified on April 1, 2009.

RESEARCH NEWS

Body Dysmorphic Disorder: a Problem of Perception?

By Jamie Feusner, M.D.

Dr. Feusner is an assistant professor-in-residence at the University of California at Los Angeles (UCLA). He has published on body dysmorphic disorder, obsessive-compulsive disorder, generalized anxiety disorder, and mood disorders and has lectured nationally and internationally on these topics. He is also the Director of the OCD Intensive Treatment Program at UCLA. He has been funded by the NIMH and the Obsessive Compulsive Foundation to study visual information processing in BDD, and has recently published the first fMRI study in BDD.

Whenever Michael looked in the mirror, he saw nothing but baggy eyelids and dark circles under his eyes. He believed they had looked that way since he was born, but it really started to bother him when he entered high school. By that time he was so self-conscious he would skip class on days when he believed he looked particularly ugly. He spent hours each day checking his eyes in mirrors and applying different types of eye creams. He couldn't stop thinking about them. Michael was so fixated on his appearance that he couldn't focus in school and his grades suffered. This contributed to his depression, and he became more and more reclusive. His friends and family didn't understand how he felt about his eyes. They told him he looked fine and should just stop thinking about it, but Michael dismissed them as just trying to be nice. He was certain about what he saw. No one seemed to understand.

Michael suffers from body dysmorphic disorder (BDD), a severe psychiatric disorder that causes people to be preoccupied with perceived physical defects and believe they appear disfigured and ugly. They are so troubled by what they perceive that they often spend hours checking themselves in mirrors, avoiding others, or trying to change their appearance, including getting cosmetic procedures. They subsequently experience significant distress and are unable to function adequately in work, school, or relationships. People with BDD often become depressed, and in many cases suicidal¹.

BDD affects about 1.7% of the population², yet is vastly under-studied and under-recognized. Some evidence suggests it is related to obsessive-compulsive disorder (OCD) because of similarities in symptoms such as having obsessive thoughts and engaging in compulsive behaviors. In addition, BDD and OCD often afflict members of the same family. Some people even suffer from both disorders.

One of the most noticeable symptoms of BDD is the sufferer's distorted perception of his or her appearance. For example, a person with BDD might believe his nose is crooked, or that he has acne scars all over his face, or that his hair is thinning; yet no one else notices these "defects." Moreover, many people with BDD are so firmly convinced that these flaws exist that no one can talk them out of it. In essence, they are often delusional. This seems to be analogous to what people with anorexia nervosa experience when they perceive that they are fat, yet to everyone else they appear to be extremely thin. What could be causing them to experience this? Could there actually be something abnormal in the way their brains are processing visual information that could account for these perceptual distortions?

Up to this point, very little was known about the neurobiology of BDD. Prior to our current study, only two small brain imaging studies in BDD had been published^{3, 4}, but neither had specifically examined visual processing. Visual processing refers to the mechanism by which one's brain takes in visual information from the external world, identifies what the person is seeing, and interprets that information. Understanding the brain basis for apparent perceptual distortions perhaps could improve our understanding of BDD and lead to strategies for better treatments.

People with BDD most often are concerned with "defects" on their face and head⁵. They constantly check their appearance in mirrors, and often scrutinize others people's faces. They tend to focus primarily on details,

usually on their face, and are not able to see the “big picture” that overall they look normal. A previous study of people with BDD that involved drawing and copying complex figures also suggested that this was occurring⁶. Another study found that they have abnormalities in face processing⁷. The results of these studies, in combination with their pattern of symptoms, led us to investigate if abnormal visual processing in the brain was underlying distorted perceptions in BDD.

To study this, we used a type of brain scan called functional magnetic resonance imaging (fMRI) to compare the patterns of brain activity in BDD sufferers to that of healthy control subjects. In order to test their visual processing, we had them view digital photographs of other people’s faces while they were in the brain scanner. In this study, we tested other people’s faces (as opposed to their own) because we did not want them to experience anxiety, depression or shame that they normally experience when viewing their own face. So by making the task emotionally-neutral and by using visual stimuli other than their own faces, we could determine if there were more general visual processing abnormalities in people with BDD.

Our brains normally process visual details, such as edges depicting contours of the nose, eyes, eyelashes, skin blemishes, exact shape of the mouth, etc., with specific visual networks. Likewise, our brains process holistic or “big picture” elements (for example spatial relationships between facial features such as the relative position of the eyes to the mouth and the general shape of the face) with other specific visual networks. We predicted that people with BDD might have an imbalance in these networks, perhaps using more detailed processing and less holistic processing. Therefore, we digitally altered some of the photographs to create some images that had only low-detail (which look blurred) and others that had only high detail (which look like line-drawings) in addition to normal photos. By doing this, we were able to use these different photo stimuli to probe the activity in different visual networks.

We enrolled 12 adults with BDD and 13 healthy controls in the study. None of the participants were taking any medications or receiving cognitive-behavioral therapy. The subjects viewed digital photographs of faces on goggles while in the fMRI scanner. We instructed them to push a button to match the identity of the faces, to ensure they were attending to them. We later analyzed the data to compare the brain activity of the BDD subjects to that of the healthy controls.

The results were striking. People with BDD used primarily the left half of their brain (left hemisphere) to process the high-detail, low-detail, and normal face types. This was in stark contrast to the healthy controls, who used mostly their right hemisphere to process faces (like many other studies have shown). Only when the healthy controls viewed the high-detail faces did they start to use their left hemisphere, which was expected since normally people use their left hemisphere to process details and the right to process holistically. This imbalance in laterality would suggest that the brains of people with BDD might be attempting to extract details from all face types, even when they have no details. In addition, they had abnormal activity in the amygdala, a region in the brain that is involved in processing emotion and fear.

This left hemisphere-predominant pattern of visual processing may account for their symptoms of focusing on details at the expense of seeing the big picture. In essence, they may “lose the forest for the trees.” For example, this suggests that the brain of someone with BDD might detect details of their skin such as pores, but cannot adequately perceive that in the context of their overall face, these pores are actually very small and, in fact, barely noticeable. These people may suffer in large part because of this pattern of perception, combined with the fact that they may assume everyone else sees them similarly.

The results from this study are the first to demonstrate that distorted perception in BDD is associated with abnormal brain functioning. The fact that this occurred in people with BDD while they viewed others’ faces, suggests that there may be more general abnormalities in visual processing beyond a self, body image distortion. The amygdala finding also suggests possible abnormalities in emotional processing regions. However, we are still at a very early stage of understanding people with BDD and how their brains work. This was a small study, and additional studies need to be performed to further investigate abnormal brain processes. In addition, if future research confirms that abnormal perception is a feature of

(continued on p. 18)

RESEARCH NEWS

(Problem of Perception continued)

BDD, it is certainly not the only problem. People also tend to have obsessive thoughts and perform compulsive or avoidant behaviors. In addition, they often overvalue appearance in general, and have a tendency toward depression and social anxiety. Cultural and societal influences most certainly play a part as well.

Nevertheless, abnormal perception may be an important feature of BDD. With the generous support of a grant from the OC Foundation, we have been able to extend this line of research to a new study investigating how people with BDD process their own faces. We also have embarked on investigations of other aspects of visual processing and abnormalities in brain structure. We look forward to building on our findings with future discoveries that can provide us with a better understanding of symptoms that result in so much suffering. With this knowledge, we can then investigate how current standard-of-care treatments of medications and cognitive-behavioral therapy affect visual processing. The ultimate goal is to rationally develop new treatments such as specific perceptual retraining methods, to remediate these abnormal brain processes.

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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.

A personal note: Maggie Baudhuin has taken over writing the Research Digest since Bette Hartley retired. Maggie has been the head librarian at the Madison Institute of Medicine for 30 years where Bette and she have worked together on the Obsessive Compulsive literature database, which now contains over 28,500 citations to OCD and its treatments.

At least 30-40 percent of people with OCD do not respond adequately to a serotonin reuptake inhibitor (SRI) alone, the recommended first-line medication treatment for OCD. Using a second medication to "augment" an SRI is often tried when an SRI alone isn't satisfactory. Unfortunately, many of the augmentation strategies that have been tried in the past have failed to produce significant improvement for many patients with treatment-resistant OCD. In this issue's Research Digest, we review several recent drug augmentation studies, including studies of riluzole (Rilutek), a glutamate modulating agent; topiramate (Topamax), an anticonvulsant with effects on glutamate activity; and naltrexone (Depade, Revia, Vivitrol), an opioid receptor antagonist. We also include a summary of studies of citalopram (Celexa), an SSRI antidepressant, combined with clomipramine (Anafranil), an SRI, and the results of a meta-analysis on atypical antipsychotic medications.

The many different neurotransmitters, neuromodulators and mechanisms of action described are fascinating and offer promise of better understandings of the biological underpinnings of OCD and ways to treat them. Each treatment appears to benefit some patients when standard SRI treatment has not helped enough. How each one may work (when they do work) is less important for patients than recognizing that there are many things to try when one treatment doesn't provide enough benefit. We would all rather have something we don't understand that works than understand why something doesn't work. We simply do not understand why one treatment or combinations of treatments works for one individual and not for others.

What are the take-home messages from this Research Digest for patients? There's lots of research going on. Science gradually accumulates knowledge about what works and what doesn't and, ultimately, why. For now, patients who aren't as well as they want to be can work with their doctors to try different single therapies (monotherapy) or combine a treatment that provides some benefit with another medicine (combination or augmentation therapy) to try to increase benefit. Since we can't predict exactly who will respond to which treatments, doctors usually start with treatments with the best evidence for benefit and that cause the fewest side effects. Subsequent choices have less research to support them and often involve a series of clinical trials, searching for benefit while minimizing side effects.

A final note: the best augmentation for medication in terms of the largest short- and long-term benefit and almost no side effects, is cognitive behavior therapy (CBT). Earlier Research Digest columns have reviewed the CBT research, as will future columns.

Riluzole (Rilutek)

There is information from recent brain imaging, genetic, and other research studies that glutamate (an amino acid neurotransmitter) may be involved in the etiology and treatment response of OCD. A few recent reports suggest that riluzole, a glutamate-modulating agent (sometimes referred to as an antiglutamatergic agent or glutamate antagonist), might be of benefit for some patients with treatment-resistant OCD and certain OC spectrum disorders such as compulsive skin picking and trichotillomania. Here we review two recent reports of riluzole for OCD.

Riluzole augmentation in treatment-refractory obsessive-compulsive disorder: a series of 13 cases, with long-term follow-up

Journal of Clinical Psychopharmacology, 28(3):363-367, 2008, C. Pittenger, B. Kelmendi, S. Wasylink, M.H. Bloch, and V. Coric

This report presents the treatment outcome for 13 individuals given riluzole to augment their current OCD medication. Seven of the 13 patients in this study improved with riluzole augmentation, with some reporting good long-term response for more than a year. Some patients reported improvement not only with OCD symptoms but also with their accompanying depression and anxiety symptoms. Also of note is that the 3 patients in this series with hoarding symptoms (which are often reported to be treatment-resistant) all showed improvement with riluzole augmentation. In this study, riluzole was reported to be generally well tolerated, and none of the 13 patients discontinued riluzole because of side effects.

An open-label trial of riluzole, a glutamate antagonist, in children with treatment-resistant obsessive-compulsive disorder

Journal of Child and Adolescent Psychopharmacology, 17(6):761-767, 2007, P. Grant, L. Lougee, M. Hirschtritt, and S.E. Swedo

In this National Institute of Mental Health study, riluzole was given to 6 children (ages 8 to 16) with treatment-resistant OCD. Although this was not a "drug augmentation" study, some of the study subjects were taking other medications, including SSRIs, during the trial period. Four of the 6 patients improved within 12 weeks after starting riluzole, and one additional patient improved after a longer trial. Two patients became almost symptom free on riluzole monotherapy. All patients chose to continue on riluzole after the 12-week trial, and no patient discontinued treatment because of side effects.

Topiramate (Topamax)

Topiramate is an anticonvulsant medication most often used to treat epilepsy and other seizure disorders. Because topiramate's actions involve effects on glutamate, this medication combined with an SRI has been one of the augmentation strategies tried for treatment-resistant OCD. Several cases of improvement with topiramate augmentation have been reported in the literature over the last few years. Published case series and open trials have also reported beneficial effects in some OCD resistant patients. Here we present the results of the first double-blind study of topiramate augmentation and also summarize the results of a case series published in 2006.

Double-blind, placebo-controlled trial of topiramate augmentation in the treatment of obsessive-compulsive disorder

Biological Psychiatry, 63:170S, 2008, H.A. Berlin, L.M. Koran, M.A. Jenike, N.A. Shapira, W. Chaplin, S. Pallanti, and E. Hollander

This is the first double-blind, placebo-controlled study of topiramate augmentation for treatment-refractory OCD. Study participants were randomized to receive either topiramate (18 patients) or placebo (18 patients) in combination with their current SSRI medication for a period of 12 weeks. Based on Y-BOCs total score and compulsion and *(continued on p. 20)*

RESEARCH NEWS

(Research Digest continued)

obsessions subscores, used to measure treatment outcome, this study reports beneficial effects of topiramate for compulsions but not for obsessions. The authors conclude that topiramate augmentation may help alleviate compulsions but not obsessions, and that the effects of topiramate on glutamate activity might be the mechanism involved in patient response to this medication.

Topiramate augmentation in treatment-resistant obsessive-compulsive disorder: a retrospective, open-label case series
Depression and Anxiety, 23:1-5, 2006, M. Van Ameringen, C. Mancini, B. Patterson, and M. Bennett

This article reports the treatment outcome of topiramate augmentation in 16 individuals with severe, treatment-resistant OCD who were either partially responsive or nonresponsive to SRI monotherapy treatment or to SRIs in combination with other medications. Patients were treated for at least 14 weeks with topiramate augmentation. Using the Clinical Global Impression-Improvement Scale (CGI-I) as the primary measure to rate patient response, this study reports that after 14 weeks, 11 of the 16 patients (68.8%) were rated as responders, with 7 of these patients rated much improved and 4 rated very much improved. Topiramate doses ranged from 100-400 mg/day. Although the majority of patients in this study (81.3%) reported medication side effects, none of the 16 patients withdrew from the study because of side effects.

Combination SRIs

One augmentation strategy that is sometimes tried for treatment-resistant OCD is the combination of two SRI medications, the rationale being that two serotonergic drugs might act synergistically to increase benefit. Since the SRIs are all potent serotonin agents by themselves, the benefit associated with a combination may be related to secondary effects of other neurotransmitters and neuromodulators unrelated to serotonin. In a situation where disappointing treatment responses are unfortunately common, whatever works is very valuable, even when we can't explain how it works. Here we review a recent study of the SSRI citalopram (Celexa) combined with clomipramine (Anafranil) for treatment-resistant OCD, with comments on an older study of this same combination.

Effectiveness of long-term augmentation with citalopram to clomipramine in treatment-resistant OCD patients

CNS Spectrums, 13(11):971-976, 2008, D. Marazziti, F. Golia, G. Consoli, S. Presta, C. Pfanner, M. Carlini, F. Mungai, and M.C. Dell'Osso

In this open label study, 20 patients who had failed to respond to at least two SSRIs as monotherapy, were given citalopram (up to 60 mg/day) in addition to their current clomipramine treatment. After one month on this combination, half of the patients in the study improved, showing continued response and even further improvement for some at one year of treatment. Tolerability of this drug combination was good, with 90% of the subjects completing the study.

This recent study supports the results of an older open label, randomized trial (S. Pallanti et al, "Citalopram for treatment-resistant obsessive-compulsive disorder," *European Psychiatry, 14:101-106, 1999*), in which patients given citalopram (up to 40 mg/day) plus clomipramine showed greater improvement than patients given citalopram alone. These two studies suggest that the combination of clomipramine and citalopram might be a worthwhile approach for patients with treatment-resistant OCD who have not responded to either of these medications alone.

Naltrexone (Depade, Revia, Vivitrol)

Naltrexone, an opioid receptor antagonist used to treat alcoholism and drug abuse, has also shown promise as a treatment for certain compulsive behaviors and impulse control disorders considered by some to be part of the OC spectrum, including trichotillomania, compulsive shopping, and compulsive sexual behaviors. Here we review a recent double-blind, placebo-controlled study of naltrexone augmentation for treatment-refractory OCD.

Naltrexone augmentation in OCD: a double-blind placebo-controlled cross-over study

European Neuropsychopharmacology 18:455-461, 2008, R. Amiaz, L. Fostick, A. Gershon, and J. Zohar

In this study, 10 OCD patients who had not responded to an SSRI or to clomipramine monotherapy were given either the opioid antagonist naltrexone or a placebo, along with their current OCD medication, for a period of five weeks. No significant difference between placebo and naltrexone was seen during this study period, and an increase in depression and anxiety scores from naltrexone was reported. Although there are studies that have shown naltrexone to be effective in

the treatment of certain compulsive behaviors and impulse control disorders, this study failed to show effectiveness for OCD.

Antipsychotic Medications

A number of case reports and other studies of SRI augmentation with various antipsychotic medications for OCD continue to appear in the literature. In a previous issue of Research Digest, we summarized the results of a 2007 meta-analysis of controlled trials of antipsychotic augmentation. Here is that same summary.

Antipsychotic augmentation of serotonergic antidepressants in treatment-resistant obsessive-compulsive disorder: a meta-analysis of the randomized controlled trials

European Neuropsychopharmacology, 17:79-93, 2007, P. Skapinakis, T. Papatheodorou and V. Mavreas

Authors evaluated the effectiveness of antipsychotic augmentation of serotonin reuptake inhibitors (SRIs) for treatment-resistant OCD by carrying out a meta-analysis of all randomized controlled trials. Meta-analysis is a mathematical process of combining and comparing research results from previous separate but related studies. Then studies were compared – 1 augmenting with risperidone (Risperdal), 2 augmenting with olanzapine (Zyprexa), and 4 augmenting with quetiapine (Seroquel). A total of 157 patients were randomized to a study drug and 148 were randomized to placebo. The overall response rates were 46% for the antipsychotic augmentation group and 16% for the placebo augmentation group. This meta-analysis supports the effectiveness of antipsychotic drugs as an augmentation strategy.

Research Participants Sought

Study on Understanding the Course of OCD: A 5-Minute Anonymous Online Survey

Researchers at Binghamton University (State University of New York at Binghamton) are seeking adults (at least 18 years old) with OCD to complete a brief online survey of how OCD develops. Participation is anonymous and typically takes about 5 minutes. The information gathered will contribute to a better understanding of the history of OCD and how it unfolds over time, potentially suggesting methods for prevention and points at which to use these interventions. In addition, we will donate \$1 per participant to support the efforts of the Obsessive Compulsive Foundation. Participation is limited to once per person. For more information please visit the following website: http://www.surveymonkey.com/s.aspx?sm=hGmN7QRzH4xkwFipUYIN_2bw_3d_3d or call (607) 777-5006.

OCD Genetics Research Study

Six academic institutions across the U.S. have joined together to examine the relationship between genetics and OCD. Recent advances in molecular biology and statistical genetics make it possible to identify and describe specific genes involved in complex illnesses such as OCD.

If you have been diagnosed with OCD and have two living parents who may be available to participate in the study, you might be eligible. Participation includes a confidential interview with you, and a blood sample from you and your parents. The interview and blood draw will be scheduled at a time and location convenient for you. Compensation is available. Your help counts!!

Contact information for all sites is provided below; if you are unsure of the closest participating site, please contact Johns Hopkins University.

Johns Hopkins University (Baltimore, MD): Krista Vermillion, at (410) 923-2918, or kvermil1@jhmi.edu

Brown Medical School (Providence, RI): Nicole C. McLaughlin, PhD, at (401) 455-6608, or nmclaughlin@butler.org

Columbia University (New York, NY): Katie Buchholz, at (212) 543-5364, or cuocgas@gmail.com

UCLA (Los Angeles, CA): Don Nathanson, at (310) 206-1350 or DONathanson@mednet.ucla.edu

Massachusetts General Hospital (Boston, MA): Casey Walsh, MSW, at (617) 724-9505 or cwalsh@pngu.mgh.harvard.edu

Study on Medication and Web-Based Therapy for OCD in Milwaukee, Wisconsin

The Rogers Center for Research & Training, Inc. is looking for participants for a research study that will test the effectiveness of a combination of medication and web-based therapy for OCD. If you or someone you know suffers from symptoms of OCD, please call us at (414) 328-3706. Eligible participants will receive study medication, web-based therapy, and compensation for time and travel.

RESEARCH NEWS

Study Exploring Omega-3 Fatty Acids and B Vitamins in Non-Medicated Children with OCD

We are conducting a research study exploring the use of omega-3 fatty acids and/or B vitamins in children who have obsessive-compulsive disorder (OCD). This is exciting research that could lead to a better understanding of nutritionally-based interventions for children who are affected by OCD. Your participation is greatly appreciated!

Participation criteria include the following:

- children between the ages of 6 and 17 years old
- primary diagnosis of OCD
- not currently, or within the past three months, on an SSRI or other medication for OCD
- not currently, or within the past three months, taking complementary or alternative substances for OCD, such as inositol, omega-3 fatty acids, fish oil, 5-HTP, Valerian root, B vitamins, etc.
- *willingness to remain medication-free for the duration of the study (1-2 months)
- willingness to not start, change, or discontinue current form of therapy
- ability to swallow large 1" capsules

Exclusions:

- known allergies to fish or shellfish
- Individuals on blood thinning medication

If your child meets the eligibility criteria and is interested in participating in this research, please notify Lisa M. Bordeleau, Principal Investigator, at n3ocdresearch@aol.com. Feel free to contact Ms. Bordeleau if you have any questions about the study.

Study on Imaging the Serotonin System in OCD

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

Key Inclusion Criteria:

- 18-55 years old, male or female
- OCD is the primary problem
- Not currently on psychiatric medications

Key Exclusion Criteria:

*Current medical or neurological problem that would make participation hazardous

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

Study on Maximizing Treatment Outcome in OCD

This study compares the effectiveness of two proven treatment strategies for OCD patients who are currently on a serotonin reuptake inhibitor (SRI) but still have residual symptoms. Participants remain on their current medication and receive either cognitive-behavioral therapy (CBT) consisting of exposure and response prevention (ERP) or an additional medication (risperidone). The goal is to compare these two augmentation strategies, each of which has been found effective in prior studies. All treatment is at no charge. Note: Patients who do not improve after 8.5 weeks of treatment will be offered at no-cost the treatment they did not initially receive (either the CBT or the add-on medication).

Key Inclusion Criteria:

- 18-70 years old, male or female
- OCD is the primary problem
- On a stable dose of a serotonin reuptake inhibitor

Key Exclusion Criteria:

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

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

Study on Sensory Symptoms in Tourette Syndrome

The purpose of this study is to understand the neurological basis for Tourette Syndrome symptoms. Participants will take part in a research study that examines blink responses to sound. Participants will come to the lab for one visit for approximately three hours. A psychiatric evaluation will be performed and personality questionnaires will be administered. Participants will need to answer a few questions to set up an appointment. Parents of participants under the age of 18 will need to call us and answer a few questions about their child to set up an appointment.

We are looking for males and females between the ages of 10 and 65 with a primary diagnosis of Tourette Syndrome. Participants can receive up to \$40 for their involvement.

For more information, contact Ashley Sutherland Owens at (619) 543-7840 or ansutherland@ucsd.edu.

Trial of Paliperidone Addition in SRI-Resistant OCD

Have you been diagnosed with OCD and not responded to past medication or counseling treatment? If so,

FROM THE AFFILIATES

you might be eligible for a study at the University of South Florida examining if adding a medication called Paliperidone helps reduce your OCD symptoms.

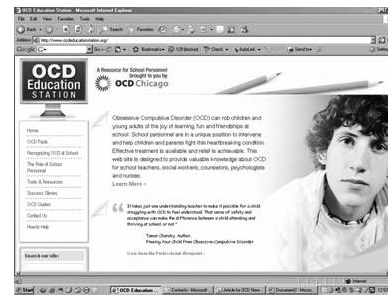
To be eligible, you must be at least 18 years old and have problematic OCD symptoms despite having tried at least two OCD medications. If you participate in this study, you will be randomly assigned, that is by chance as in the “flip of a coin,” to receive either the study medication (Paliperidone) or a sugar pill in addition to the medication you are currently taking. There will also be eight psychiatric evaluations that take place. Study medication and evaluations will be provided free of charge. Participants will also receive financial compensation for their time.

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

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.

ILLINOIS

OCD Chicago Unveils its OCD Education Station



The OCD Education Station, a new section of the OCD Chicago website designed to help school personnel understand OCD, was released in late October 2008.

OCD is one of many childhood and young adult anxiety disorders that can seriously affect a student’s performance in school; it can rob youngsters of the joy of learning, fun and friendships. School personnel are in a unique position to intervene and help children and parents fight OCD, and to let them know that effective treatment is available and that relief is achievable.

Written from a school professional’s perspective, the Education Station is designed to provide school teachers, social workers, counselors, psychologists and nurses with information and resources on skills and tools to work more effectively with students who have OCD and their parents.

To view the OCD Education Station, visit the OCD Chicago website, www.ocdchicago.org, and click on the School Personnel tab, or visit the OCD Education Station directly at www.ocdeducationstation.org.

MASSACHUSETTS

OCF of Greater Boston’s Les Grodberg Memorial Lecture Series

The OCF of Greater Boston (OCF/GB), in conjunction with McLean Hospital, presents a lecture series featuring distinguished speakers in the field of OCD and related disorders. Each presentation takes place from 7:00 – 8:00pm and is held in the De Marneffe Cafeteria Building, Room 132 at McLean Hospital in Belmont, MA 02478. Below is their Winter 2009 lecture schedule:

February 3, 2009	Treating Intrusive Thoughts	Carol Hevia, Ph.D. OCD Institute, McLean Hospital
March 3, 2009	Adapting CBT for BDD in Ethnic Minorities	Luana Marques, Ph.D. Massachusetts General Hospital
April 7, 2009	Body-Focused Repetitive Rituals	Deb Osgood-Hynes, Psy.D. Center for Behavioral Health, LLC
May 5, 2009	The Role of Guilt in OCD	Leslie Shapiro, LICSW OCD Institute, McLean Hospital

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

The OCF/GB affiliate is pleased to announce that it will be sponsoring a new professionally-led parent support group directly before each monthly lecture. This group will run from 6:00 – 7:00pm in the De Marneffe Cafeteria Building, Room 116 at McLean Hospital. Babysitting will be provided.

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FROM THE AFFILIATES

Following each speaker presentation there are also several free self-help groups open to the public. For more information on these support groups please contact Denise Egan Stack, the OCF/GB President, at (617) 855-2252. These groups will begin at 8:00pm and run until approximately 9:30pm in rooms 114 and 132. The identity of participants and content of group discussion must remain confidential. Furthermore, if desired, you may remain anonymous. We remind participants to be open and supportive to the views of all those who take part in the support groups.

NEW YORK

Central New York OCF Affiliate Takes Part in Local Health Fair

In late October 2008, several members of the Central New York OCF (CNYOCF) Affiliate's Board of Directors participated in a day long annual health fair held at the State University of New York (SUNY) Institute of Technology in Utica, NY.

Their free handouts, displays, and continuous play videos drew much attention from the participants, and they encountered several hundred community residents who left with a better understanding of OCD. Some contacts even resulted in new members joining the CNYOCF support group.

PENNSYLVANIA

OCF of Western PA (OCF/WPA) Announces its Upcoming Events

February 16, 2009

Andrew Gilbert, MD

Lecture: Treating Children with OCD

Erie, PA

Open to Mental Health Professionals only. Free.

March 11, 2009 at 7:00 PM

Pizza Party

1011 Bingham Street

Pittsburgh, PA

Join the OCF/WPA for a night of pizza and camaraderie. Kids can ask an attending therapist questions about OCD, or simply socialize with their peers. Parents of children with OCD will be able to meet with Andrew Gilbert, MD, for a question and answer session. Adults with OCD, as well as their support network, can meet with Robert Hudak, MD, to ask questions and discuss OCD. Admission is free.

May 8, 2009

Spring Conference: Effective Treatment for OCD

Sheraton Station Square

Pittsburgh, PA

Alec Pollard, Ph.D., Director of the Anxiety Disorders Center at the St. Louis Behavioral Medicine Institute and course director of the OCF's Behavior Therapy Institute, will deliver a keynote address. The course goals are to educate therapists and the general OCD community on the latest advances in the effective treatment of OCD. Continuing education units will be available for qualified professionals. Tuition will be charged for this event. Details will be listed on www.ocfwpa.org.

For additional information on any program, email Elaine at ocdirections@verizon.net or call the OCF/WPA hotline at (412) END-OCD1.