INTERNATIONAL OCD FOUNDATION

OCD Newsletter

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FROM THE FOUNDATION

International OCD Foundation Launches New Website

Packed with expanded and updated information about OCD and OC Related Disorders, the new IOCDF website (**www.ocfoundation.org**) launched in late November 2009 to rave reviews. More than 1 million online users visit our site each year and many of them have praised the more intuitive site navigation and the breadth of new, easy-to-understand content in the "About OCD" section.

The new "About OCD" section (**www.ocfoundation.org/whatisocd.aspx**) includes detailed information about the diagnosis and management of OCD and OC Related Disorders in both children and adults, ideas for parents and family members, and summaries of the newest treatment strategies such as glutamate and deep brain stimulation. For those newly diagnosed with OCD, a Glossary of Terms (**www.ocfoundation.org/glossary.aspx**) is also available to help people understand the terms used throughout the site. More experienced visitors will also benefit from a new "Expert Opinions" (**www.ocfoundation.org/expert.aspx**) page, which will feature articles written by experienced OCD professionals.

Our new Annual Conference page (**www.ocfoundation.org/conference.aspx**) lists information about the conference's program, provides information and tips about conference travel, offers links to area attractions, and even points visitors to an online bulletin board dedicated to discussing the conference.

During October 11-17, 2010, the website will also advertise our OCD Awareness Week efforts. Visitors will be able to learn more about ways to spread the word about OCD in their community during Awareness Week, or at any time, by visiting **www.ocfoundation.org/Week.aspx**.

Other highlights include a redesigned "Research Participants Sought" page (**www.ocfoundation.org/participants.aspx**) that organizes ongoing studies by location, a newsroom section (**www.ocfoundation.org/newsroom.aspx**) that lists OCD-related newspaper, radio, television, and internet appearances, and a redesigned "Online Support" page (**www.ocfoundation.org/yahoo.aspx)** that lists over three dozen online support groups.

In the upcoming year, we will be adding many more pages to the website, as well as a revamped treatment provider, support group, and intensive treatment program search tool. This new tool will allow users to view much more detailed information about providers in their area and will even allow users to search by any landmark recognized by Google Maps. Need to find a provider near Times Square? Our search engine will be able to help.

IN THIS ISSUE

FROM THE FOUNDATION

Other planned improvements include an expanded hoarding section, the return of our "Ask the Experts" section, and a free archive of past newsletters.

You can also keep track of website and IOCDF updates as they happen by visiting our "What's New?" blog. Check it out today by visiting **www.ocfoundation.org/whatsnew.aspx**.

What do you think about our new site? We welcome your feedback! If you have a suggestion for a new feature or an improvement you'd like to see on our website, please email us at **info@ocfoundation.org**.

Thank you to all of our website contributors!

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IOCDF Support Group Database under Construction

If you have visited the IOCDF's new website recently, you might have noticed that our support group database is currently unavailable. Over the next couple of months we will be updating every support group listing in our online database in order to ensure that we are providing the most accurate contact information for OCD groups that meet across the country. We appreciate your patience as we perform this much-needed database renovation.

If you currently lead or belong to an OCD support group and would like to have a listing for your group included in our new database, please email **rcyr@ocfoundation.org** with the following information:

- Contact person for group
- Email
- Meeting location
- Fee (if applicable)
- Group open to (Adults, Teens, and/or Children w/ OCD; Parents of children with OCD; Family Members/Friends of people with OCD, etc.)
- Phone
- Website
- Meeting days and times
- Group type (OCA, Professionally led, Mutual support, etc.)
- Additional info

Thank you for your help!

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

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

Message from the President

Dear Friends,

As I write this message, the New Year is fast approaching and will have already passed by the time you receive this newsletter. I know at this crazy time of year it is often hard to find the time to stop and think about the people and organizations in our lives that have been important to us. I hope, however, that you will remember the IOCDF's Year-End Appeal and Research Appeal in your charitable giving, as it is only with your help that we can continue with our important mission. For those of you who have already given, we thank you so much for your contributions!

This year we tried to liven up our Year-End Appeal by sending out an invitation to a "No-Show Ball," which you can see pictured on this page. We were hoping this would be a little more fun and interesting than our usual appeal letter. I can only hope that you found it so clever that it inspired you to give even more than usual!

I know that the people who tend to contribute to our Year-End and Research campaigns are those who have used our services more recently. However, I would like to make a special appeal to those of you who may not have reached out to us for some time. I hope you remember that we are still here to help you and your loved ones, and that we continue to help many others in need each and every day. As you can see from the "No-Show Ball" invitation, it does not take a big donation to make a difference. Every donation, no matter how small, can help us continue to provide the services and programs that people rely on each day. So, please don't think that because you cannot make a large gift that your donation will not be put to good use. Our average donation is less than $50, and it is through smaller donations such as this that our organization is based.

Fundraising is not the only thing on our minds these days! If you have been to our website recently, you would have noticed that we have completed the upgrade to our site, which has updated information and new search features. Please feel free to give us feedback about what you think. We are continuing to work on it, so you will continue to notice updates and changes as we move through the year. We are also busy working on our 17th Annual Conference, which is taking place July 16-18, 2010 in Washington, DC. Although it might seem far away, it feels as if it is right around the corner for us, so we are busy getting the program organized. We are anticipating this will be a record-breaking year for us in terms of attendance, so be sure to book your travel arrangements and hotel rooms early.

As this New Year begins, I wish all of you a happy and healthy 2010. I know that for many of you the struggle of OCD might prevent you from finding true enjoyment in your lives, but I hope that you will all continue to partner with the IOCDF in order to help everyone with OCD to find peace and fulfillment in their lives this year and into the future.

Diane Davey
President, International OCD Foundation Board of Directors

FROM THE FOUNDATION

Conference Highlights

More than 100 presentations including introductory and advanced programs for individuals and families.

Special sessions include:

- Friday Night Support Groups
- Friday Night Virtual Camping Trip
- Kids & Teens Programs
- Experiential Workshops
- 4-hour Pre-conference Training on July 15 (limited to professionals only)
- Professional track offering up to 18 CME and CE credits for physicians, nurses, social workers, psychologists, professional counselors, and marriage and family therapists
- Single-day and full-conference registrations available

Who Should Attend?

- Individuals (adults, teens and children) with OCD or any of the OC Related Disorders
- Parents, spouses, siblings, children, caring friends and other relatives of anyone with OCD or OC Related Disorders
- Physicians, nurses, social workers, psychologists, professional counselors, marriage and family therapists, and other professionals who provide therapy, support and information to those affected by OCD and OC Related Disorders

Registration will open by March 15, 2010

Early bird registration discounts end on June 16, 2010 at 5pm EST

To Register:
Visit http://www.ocfoundation.org or call (617) 973-5801.

For more information on presentations, instructors, educational objectives, costs, and conference hotel, contact us at conferences@ocfoundation.org or (617) 973-5801.

FROM THE FRONT LINES

Aging and OCD: My Personal Research Project

By David Rich

My Story

I am a 76 year old retired lawyer who has had periodic episodes of OCD involving intrusive thoughts most of my life. Fortunately, these painful times didn't last longer than six to eight months. I was doubly fortunate because if I got caught up in an obsession and told my "secrets" to a psychotherapist, contrary to the experience of most OCD sufferers, this had a very beneficial effect on me. However, in 2005 an obsession started which bit harder and was more tenacious than anything I had experienced before. I was in a deep funk for 3 years despite the help of two dedicated psychotherapists and a behavioral therapy expert.

With that base of assistance, I have made excellent progress over the last year and a half, thanks to a wonderful cognitive therapist at the Massachusetts General Hospital OCD Clinic. I am in good shape again with, I hope, a more realistic grasp of how OCD functions and a more mature sense of what can be done to alleviate its symptoms and how to live with it as a part of one's life. I attribute much of the power of this episode to the fact that it arrived concurrently with my beginning to confront the existential issues of declining physical and mental capacities, loss of resiliency, old age, and death.

This unusually tough bout started me thinking about others of my generation and wondering how they were experiencing OCD as the years advanced.

The "Project"

I had met Jeff Szymanski and Diane Davey during my 10 years of volunteering at the OCD Institute at McLean Hospital and talked with them about doing an informal study. With their encouragement, I decided to go ahead. In early 2009, I sent letters to 180 therapists in New England and New York who were listed in the International OCD Foundation's treatment provider database. In these letters, I asked the therapists if they could identify any patients 65 and older with OCD who would be willing to discuss their experiences with me. After receiving a modest amount of feedback, I sent out follow-up postcards in July.

Ultimately I received 53 responses. Fourteen therapists reported having or having had a patient 65 or older. Only five indicated meeting more than one such patient in the course of their career, and only two of that group had had multiple patients in that age range. Assuming that those who didn't answer had not had any such patients, the numbers suggest that the 180 therapists that I contacted have only treated 27 patients age 65 and over during the course of their careers.

To date, I have interviewed five people in person, and received answers to questionnaires from three people for a total of eight. In addition, therapists did contact nine other patients who, because of

(continued on p. 6)

FROM THE FRONT LINES

(Aging and OCD, continued)

confidentiality or other personal reasons, ultimately didn't wish to participate. (For the record, four of the people who did participate were referred to me from non-therapist sources.)

"Results"

Of this "sample" of eight individuals, two have hoarding problems, two primarily with perfectionism, two with contamination, and two with scrupulosity, and one person also reported that her primary concerns were obsessing about remembering names. The ages of the group range from 67 to 84. Three are living with spouses. All have families and/or friends who are supportive. I believe all are living in decent environments and have at least a reasonable standard of living. All appear to be in relatively good health and try to remain active. To varying degrees, all are what one person described to me as "fighters" who have definite OCD problems but are not giving in and working to lead the best life they can.

There was no clear-cut pattern demonstrating that OCD might differ with age. Onset of symptoms occurred anywhere from childhood until the 30s and 40s, with the exception of one person for whom OCD was not a problem until retirement suddenly triggered obsessive concerns about the welfare of loved ones.

Diagnosis generally occurred many years after symptoms first began and had to be endured without appropriate assistance. One person had years of psychotherapy which didn't help a hoarding problem. OCD-effective treatments rarely began before middle age. Two people, in treatment for many years, reported "steadying down" and "becoming more accepting" as time has passed. Another person didn't talk about acceptance but did report that, despite very difficult experiences recently, including long confinement to bed, that the worst time of her life was trying to live with OCD in her 40s without any knowledge of what was happening to her or therapeutic assistance of any nature, while trying to raise a family and manage a household. Only one person, who is over eighty, specifically said that his OCD had increased in intensity. He was the only person interviewed who is not receiving any treatment. Two didn't note any meaningful difference between their OCD then and now. Two are just beginning to receive appropriate help. For two people, alcohol was a problem that had to be dealt with concurrently with their OCD. Both spoke admiringly of the AA 12 step program. In all cases OCD remains a problem to be lived with and managed. No one has "licked it."

A Big Need

The most striking fact that emerges from this small sampling is how few seniors, even in the therapy-conscious Northeast, are receiving individual treatment. Only 7% of 180 therapists reported having had any experience with the senior OCD population and that experience has been very limited in number. If we assume that seniors are just as apt to have OCD issues as any age group, then there must be a vast number who are trying to live with OCD without appropriate assistance and even without any knowledge of why they are so troubled.

From my vantage point, it didn't seem to be a problem with the therapists. If the patients came, they would see them. It appears that seniors are not getting information about OCD and available treatments and, as several therapists indicated, there can be a reluctance to undertake treatment for the older age group even when treatment is accessible. Accessibility itself undoubtedly can be a problem in parts of the country but the fact that the statistic comes from the Northeast where therapists are most plentiful suggests that lack of awareness is a major issue.

There is a powerful need to find ways to create more OCD awareness and make more treatment opportunities available to seniors. There is an equally powerful need for research to obtain more information as to what may be special about OCD in old age, what can be done to decrease reluctance to undertake treatment, and what treatment adaptations may be helpful and necessary in serving an aging population. I hope that the International OCD Foundation and the therapeutic community will band together to address this situation.

Finally, for my own part, I would very much like to continue and broaden participation in this project and would welcome the opportunity to interview (personally, through questionnaires which can be answered anonymously or otherwise) anybody 65 and older who is willing. I look forward to hearing from therapists with such patients or anyone willing to share their experience about OCD. I can send copies of the questionnaire I have mentioned to anyone interested. I would also be very happy to have any comments, suggestions and/or information of any sort from anyone on this article and the subject of aging and OCD in general. If you wish to contact me, my email is **davtrch@aol.com**.

YouTube Broadcast Yourself™

Find us on Facebook

Did you know that the International OCD Foundation has a You Tube channel and a Facebook page?

To watch videos, PSAs and interviews with our Speakers Bureau members, visit our You Tube channel at **www.youtube.com/iocdf** and subscribe for free today!

To get regular updates about current events, read about new developments in IOCDF programs, and stay connected with the IOCDF community, go to our Facebook page at **www.facebook.com/pages/International-OCD-Foundation/153834917994** and click on the "Become a Fan" button at the top of the page.

Mark Your 2010 Calendar Now for the Next IOCDF-Sponsored Behavior Therapy Training Institute

June 11th, 12th, & 13th, 2010
Rogers Memorial Hospital
34700 Valley Road, Oconomowoc, WI 53066

In-Depth 3-Day Training Program in State-of-the-Art Cognitive Behavior Therapy for OCD

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

Faculty

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Clinical Assistant Professor of Psychology, Rosalind Franklin University
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C. Alec Pollard, Ph.D.
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Professor of Community and Family Medicine, Saint Louis University

This program is sponsored by the International OCD Foundation (IOCDF), Inc. This program has been approved by the National Board for Certified Counselors (Provider #SP-1737). Course meets the qualifications for 21 hours of continuing education credit for MFCCs and/or LCSWs as required by the California Board of Behavioral Sciences (Provider #PCE 4422). Renewal application has been made to the National Association of Social Workers (Provider #886509959) for 21 continuing education contact hours. IOCDF is approved by the American Psychological Association to sponsor continuing education for psychologists. IOCDF maintains responsibility for this program and its content.

Please check www.ocfoundation.org/BTTI.aspx for more details.

FROM THE FRONT LINES

Beyond a Shadow of a Doubt

By Chris Kelly

The judge greeted the newly impaneled jury and optimistically announced that the criminal trial would wrap up in a day or two, including jury deliberations. I guess he made the prediction based on the type of case, the number of witnesses and his years of experience.

Little did he know that one of his jurors was gripped by the OCD monster of doubt. The trial dragged on for three days.

I agreed to serve on the jury because I thought my OCD would be an asset. I was detail-oriented and assumed that the trait would be helpful in sorting out the evidence. My habit of over-checking and questioning the accuracy of information in daily life would, I thought, help serve justice in the courtroom.

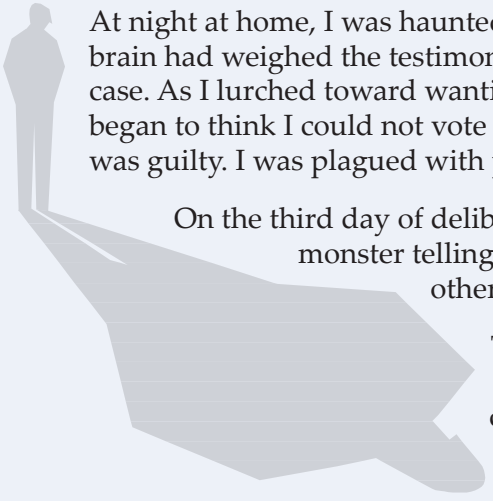
But as the trial started with opening statements by the lawyers, I was instantly seized with terror about whether I would make the right decision. The judge said that the jury could convict only if we thought the defendant was guilty "beyond a reasonable doubt." It suddenly occurred to me: As a person with OCD, I often could not determine which doubts were "reasonable."

The defendant was accused of crimes that, if convicted, could result in him spending the next several decades, perhaps the rest of his life, in prison.

When the lawyers finished presenting their cases and we arrived in the jurors' room, everyone was impressed with the prosecution's case. Juror No. 2 said, "Let's convict and get out of here." That, thankfully, did not get support. Another juror said, "Even if we all think he is guilty, let's review the evidence to be sure." I loudly agreed, of course.

And then, spurred on by me, we reviewed, and re-reviewed, every shred of evidence. Discussion ranged on for hours about chronology, witnesses' statements and the lawyers' presumptions. We turned over every rock. (To this day, I'm not sure whether I was a champion for justice or an unnecessary pain in the butt to my fellow jurors.)

During the day, I was taunted by juror No. 2, who informed me that she was furious because I was keeping her from her home life. When I asked questions about the evidence in the jury room, she would roll her eyes and snicker.



At night at home, I was haunted by the OCD monster while trying to sleep. The intellectual part of my brain had weighed the testimony with sound judgment, and I saw that the prosecution had proven its case. As I lurched toward wanting to convict, the monster demanded beyond 100 percent certainty. I began to think I could not vote to convict without a magical sign from the heavens that the defendant was guilty. I was plagued with panic attacks.

On the third day of deliberations, I couldn't deny my intellect any longer. Despite the OCD monster telling me I would somehow be punished, I announced, to the relief of all of the other jurors, that I agreed with a conviction.

Then, as we rose to return to the courtroom, the monster began telling me, "You can't convict, you'll be wrong, wrong, wrong." I walked into the courtroom with my heart pumping hard and entered the jurors' box. The judge queried the foreman, who announced the guilty verdict. As they started to poll the jury, I had a foreboding that I would blurt out that I had changed my mind. I started hyperventilating. When it was my turn to speak, I fortunately said, "yes" (but with enormous anxiety). There was no hung jury, as some of my fellow jurors had feared because of me.

In the end, justice was served for the assailant's victim and society at large. Unfortunately for me, the OCD showed no mercy.

YOUTH CORNER

Randy's OCD

By Hunter Buchanan

This is a school writing project by my youngest son, Hunter. The project was to write about a time when he had helped someone. I asked him to think of a time when he was a BIG help to someone, and he mentioned helping his brother one time with some ERP. We then elaborated on how he is very patient and kind when Randy is having an OCD episode and how that is helpful too. He decided to write about that and this is the final outcome. We were very proud to receive a call from his teacher saying how touched she was by his story. I, of course, also saw it as a victory for OCD awareness. Here is Hunter's 4th grade writing project about his brother's OCD. –L. Buchanan

"Splash!" as I jumped into the pool. "Hey Randy, do you want to play wrestle?" I asked in curiosity. "No," he answered, curled up in the corner of the pool. I wondered what was wrong. He always wanted to play wrestle. I thought to myself, "Oh well, he'll want to play tomorrow."

The very next day I asked, "Hey Randy, do you want to play football?" "No, you might have germs on your hands and then put them on the football," he replied. Now I was thinking something was definitely wrong but I didn't know what. So I told my Mom and she told me, "I took Randy to the doctor and they said that Randy has OCD." "O-C-what now!?" I exclaimed. "Obsessive Compulsive Disorder." First I asked her about what had just happened between Randy and me. She explained that what Randy did was because of his OCD, and that it wasn't really Randy. His OCD brain was telling him a lie (that I had germs on my hands and that I would get them all over the football).

I was as scared as a trailer in a tornado. I looked at the sun and it was crying thousands of millions of tears. I thought my brother was gone forever, and I would never see my old Randy again. After a couple of weeks I was in shock that my brother would never play with me again unless my Mom bribed him. My Mom told him that if he played with me for two minutes, that she would give him extra time to play video games. He replied, "OK, I'll do it - but after, can I wash my hands?" "Fine by me," Mom agreed. "What do you want to play?" Randy asked. "Want to play hockey?" I asked. "Sure," he said with a frightened look on his face.

"Goal!" I yelled. Then Mom stuck her head out of the door and yelled, "Your two minutes are up!" Randy ran for the door. "Aww man, now I don't have anyone to play with! It's getting dark and I have to go in now and do this all over again tomorrow. Oh boy," I thought sadly.

OCD is a bad thing and there are two types of OCD that I know of. One is when you think everything is poison but it is not. The other is when you keep doing stuff over and over again and you do it every time you see it. Like touching a doorknob six times before you leave the room. That's OCD. Also, having to wash your hands over and over until they're red and sore. That's OCD. I also learned it's what is called a brain disorder and that Randy couldn't make it stop by himself. He went to some doctors called therapists and they helped him with medicine and by doing OCD homework.

Even though I was sad, I knew that I was helping him too. I helped him to play with other kids and play with me even though his OCD was telling him not to. Now, Randy's OCD doesn't come to mess with him that much anymore, but he knows if it comes back to bother him I'm there to help him out.

THE THERAPY COMMUNITY

How Much Is Too Much?

Fred Penzel, Ph.D.

Fred Penzel, Ph.D., is a licensed psychologist who has specialized in the treatment of OCD and OC Spectrum Disorders since 1982. He is the Executive Director of Western Suffolk Psychological Services, a private treatment group in Huntington, NY, and author of "Obsessive-Compulsive Disorders: A Complete Guide To Getting Well And Staying Well," a self-help workbook covering OCD and other OC Spectrum Disorders. He is a founding member of the International OCD Foundation's Science Advisory Board and has been a frequent contributor to the IOCDF's newsletter.

Following a panel discussion entitled "The Ethics of Exposure: When and Why to do ERP, And Is There Such a Thing as Too Far?" at the International OCD Foundation's 2009 Annual Conference in Minneapolis, it seemed to me that this was a topic that merited some follow-up in the IOCDF's newsletter as a matter of importance to OCD consumers. Although I kept a record of what was said, I neglected to note who said what, so I will simply credit the panel members, Drs. Patrick McGrath, Charles Mansueto, Jonathan Grayson, Robin Zasio, Eda Gorbis, Alec Pollard, Lisa Hale, and Brad Riemann with having contributed some of the points I will be mentioning here. This isn't a transcript of what was said; rather, I will simply discuss the issue in a more organized way, together with some thoughts of my own.

The whole topic of how behavior therapy for OCD should best be conducted is an important one. Behavioral therapy (BT) for OCD first began with the publication of Victor Meyer's 1966 study, which was a single case report in the journal *Behavior Research and Therapy*. Since then, the field has greatly expanded, with many different professionals weighing in with their studies and views on how therapy should best be conducted. Behavioral therapists do not all work from the same 'cookbook.' They each put their personal stamp on a set of accepted principles. What we have now is a whole range of individual approaches to BT, varying from the conservative to the more radical.

The overarching concept behind what we do in behavioral therapy for OCD is this: That sufferers can learn to overcome their fears by gradually facing those fears and by challenging their theories about what will happen if they do. There is no way someone can overcome anxiety without facing it in one way or another. The question here is how they can best do this – i.e., how far to go in facing fears, and how rapidly it should be done. This is not a matter to be taken lightly, as it can spell the difference between success and failure for each patient.

For example, a new patient related to me how he had dropped out of his previous treatment after the first exposure session. He had been taken out into the community for the first day of what was to be a three week course of intensive treatment. The therapist was a fairly new one, and she asked him to touch several things in a public place. He recounted, "The things she asked me to touch were right at the top of my list of fears, even though this was our first treatment session. I did what she said, even though I was totally freaked out. I wanted to say something, but since she was my therapist, I didn't think I should be telling her how

to do her job. I decided to not go back the next day. It took me several days afterwards before I could calm down." While it could be said that this was simply a mistake on the part of a novice therapist, it also highlights a more important issue: Therapists relative to patients are in a position of authority. They have power and influence in the therapist/patient relationship. Patients are paying the therapist, willingly putting themselves in their hands, and hoping to get approval and positive feedback about their progress. This authority, like all authority, can be misused, no matter how well-intentioned. While it is true that patients have some shared responsibility for their own treatment and should ideally give the therapist feedback, some may not have the confidence or assertiveness to question or challenge what they are being asked to do. This is because they may be in a state of depression, distracted by their thoughts, in an anxious state, or feel weak and poorly about themselves. It is also the responsibility of the therapist to be able to *read* the patient and create a treatment plan that is practical and realistic for that particular person and tailored to his/her specific needs. Therapists can push patients too far in different ways for a variety of reasons. Inexperience is the most obvious one, and possibly the most common. Other reasons might include a kind of zeal and perfectionism about treatment where they feel they have to go in with all guns blazing. Some may even take a strange kind of pride in being more radical and creative than other therapists. They may even brag to colleagues about how far they have gone with patients. Others may simply be insensitive to patient distress or have poor clinical judgment.

What is being advocated here is for therapists to take a reasonable and humane approach. It all begins with good training and supervision of therapists in training. Beyond this, there are several other points that should be made here. The importance of the proper assessment of patients cannot be stressed enough. Only by making a careful behavioral analysis of each patient's symptoms can we know exactly what we are treating, the circumstances, the function of each symptom, and the severity of each symptom, both individually and relative to all other symptoms. One of the reasons we do this is to be able to create a rank ordering of symptoms from the lowest level to the highest. Therapy tasks are then drawn from such a list. The goal in treatment is to gradually build feelings of success and effectiveness as patients work their way up the list, and see that they can gain control over their disorder. Guiding patients to then work on their tasks is the next step, and it is a crucial one. There is a fine line between encouraging someone who is merely overcautious, and pushing someone who simply isn't ready to do something. This should be done with finesse rather than brute force or coercion. It could be seen as the difference between attacking the problem with a scalpel versus a sledgehammer. It also calls for creativity and even humor at times. By this, I don't mean being creative in going further than any other therapist. It is creativity in finding exposures that are the most efficient and intelligent, and that cause the patient to face no more anxiety than is really necessary. It is creativity in pacing the patient's overall therapy, from the first exposure to the last. It is why we don't begin to teach people to swim by throwing them into the deep end of the

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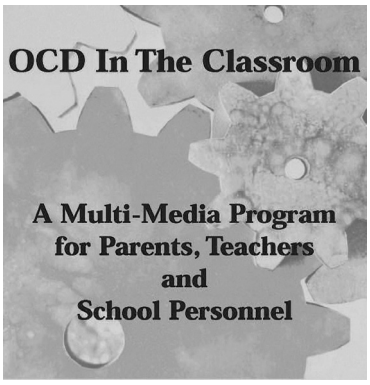
"OCD in the Classroom" Kits Available Through the IOCDF!



"OCD in the Classroom" is a multimedia program designed to educate school professionals about the effects of OCD on a child's performance in the classroom. The kit was designed to be presented by parents of children with OCD, mental health providers, and/or interested teachers and administrators. The kit contains all the materials and information needed for anyone to lead this presentation, including:

- Presenter's Manual
- Transparencies
- Two videotapes (and a DVD containing the same material)
- Various pamphlets on OCD
- Past issues of IOCDF newsletters

"OCD in the Classroom" is available for $15/kit, plus shipping and handling. To order one today, call our national office at (617) 973-5801.

THE THERAPY COMMUNITY

(How Much Is Too Much, continued)

pool. Therapists should focus on the difference between *graduated exposure* and *sudden total immersion*, although a kind of gradual and total immersion is the ultimate and long-term goal. There are times when negotiation with patients is called for, as a way of gradually approaching therapeutic goals. Patients, after all, need to be partners in their own treatment and should always be regarded as such. If something cannot be done in one step, perhaps it can be divided into two or more. Therapists should be asking themselves, "What are all my options? How can I do the most with the least?" If it appears, at first, that a fairly high-level exposure or one that the patient is reluctant to do is called for, the therapist needs to consider, "Is there some other way? Is there another way I can get the patient recovered without this?" If there genuinely is no other way, this must be clearly explained to the patient. This does not mean that therapists must be timid or hesitant when it comes to treatment. There are clearly times when boldness and decisiveness are called for, but these must be guided by logic and judgment.

Some particular areas of OCD treatment that need to be handled with care would include:

- Religious scrupulosity
- Thoughts of harming others (morbid obsessions)
- Obsessions about suicide
- Compulsive perfectionism (when directed by the patient at their own treatment)

When treating religious scrupulosity, we walk a fine line between giving effective assignments and infringing on people's deeply held beliefs. It can sometimes help to get advice on this from religious authorities. In the case of treatment assignments for murderous or violent thoughts, we must beware of how much risk we are asking patients to take with themselves or others. Suicidal obsessions must be carefully assessed so the therapist can determine that they are merely obsessions and not symptoms of a concurrent major depression. Certain patients need to be protected from themselves. They may have doubtful obsessions telling them that if they do not do therapy perfectly, they may never recover. This can sometimes lead them to go to extremes of their own in doing assignments, sometimes going way beyond what was intended by the therapist. This needs to be recognized in patients, and they usually need to have their assignments clearly spelled out for them, with limits clearly defined. They may even have to be exposed to the obsessive thought that they are doing therapy imperfectly and will therefore not recover.

Let me conclude by saying that beyond our main principle of doing patients no harm, there are several other principles that therapists might want to consider including as part of their approach to treatment. These would include:

- Never ask a patient to do anything that might humiliate them.
- Do not ask patients to do anything that would violate the true principles of their religious beliefs. Do not hesitate to get advice from religious authorities on these matters.
- Do not use a more extreme approach if a less extreme one is available. If possible, try to divide up tougher assignments into manageable bites.
- Before asking patients to do something, be sure to first determine if the patient is ready or willing to do it.
- Give patients choices and encourage them to be partners in their own treatment, rather than simply dictating to them. They are more likely to carry out assignments that they have had a hand in choosing.
- Don't do assignments along with patients if doing so would compromise the therapist/patient relationship.
- Overall, be humane and treat patients the way you, yourself, would want to be treated.

Integrating Technology into Cognitive-Behavioral Treatment for OCD

By Jonathan Hoffman, Ph.D., Eric Storch, Ph.D., E. Katia Moritz, Ph.D., and Jason Spielman, Psy.D.

Drs. Hoffman and Moritz are the Clinical Directors and Dr. Spielman is the Director of Program Services at NeuroBehavioral Institute in Weston, Florida. They are all Licensed Psychologists in the State of Florida and are associated with the Dan Marino Center, Miami Children's Hospital, in Weston, Florida. Dr. Storch is an Associate Professor of Clinical Psychology in the Departments of Pediatrics and Psychiatry at the University of South Florida and is a member of the International OCD Foundation's Scientific Advisory Board.

What is the bottom line on the application of technology in OCD treatment? Promising, but proceed with caution. The authors presented on this topic at the International OCD Foundation's 2009 Annual Conference in Minneapolis.

Imagine a future in which Cognitive-Behavioral Treatment (CBT) for OCD can be done without ever having to visit a therapist's office. The therapist can appear on your computer or your phone, maybe even on a tiny camera you wear that allows him or her to see what you are experiencing in real life exactly as it is happening. Now imagine it's not even a living therapist but a computer-generated "virtual therapist" that has all the collected knowledge of many OCD specialists in its memory and can instantly tailor treatment for any individual's unique OCD symptoms. What if the technology of virtual reality (VR) becomes so advanced that it is indistinguishable from real-life (in vivo) Exposure and Ritual Prevention (ERP)? If you suffer from obsessions about germ contamination, you just put on a VR headset and VR gloves that would expose you to all the sights and sensations of germs and encourage you to not leave or cleanse until you mastered the exercise (habituated). What if sensors could help you instantly monitor how well you were habituating to a specific discomfort? Is any of this really possible? Well, some of it is already available (e.g. VR technology) and some of it is not quite possible yet, but there is no doubt that advances in technology have already expanded CBT treatment for OCD and that this process is accelerating rapidly.

At the present time, one promising note is that technology can potentially increase access to both primary and adjunctive OCD treatment. Many people with OCD do not live near specialized practitioners or are homebound; videoconferencing over the Internet can bring CBT expertise to you via your home computer. When videoconferencing on the Internet, important clinical information (e.g. facial expressions) is not totally lost even if you cannot see body language in its entirety. The ability to enter a patient's natural environment can help the therapist better understand how symptoms have affected daily functions and living conditions. Doing exposure therapy "in-video" in the home and, in some cases, the work environment might actually create a better platform for exposure and generalization than some office visits.

For example, Dr. Spielman gave a live demonstration of the potential of videoconferencing for OCD treatment with the help of a patient from the Bahamas. On cue, the patient appeared on screen and described how videoconferencing had helped her after going through an intensive CBT treatment program in the US. She also shared with the audience that having sessions over the webcam at her own home had allowed her therapist to

(continued on p. 14)

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(Integrating Technology, continued)

notice the true condition of her living space. It was noticed how many items she had been collecting. Prior to the videoconferencing sessions, hoarding was an OCD symptom that she had not yet been able to identify as an important symptom to address. In subsequent videoconferencing sessions, her hoarding was successfully treated.

Research about videoconferencing in OCD treatment is an emerging area of interest. Dr. Storch discussed his study regarding Videophone-Administered CBT for youth with OCD. This is an ongoing study funded by the Florida Mental Health Institute that examines the effectiveness of CBT in pediatric OCD when administered via webcam. Although a sizable amount of literature exists examining computer-assisted behavioral psychotherapy, this approach has yet to be examined in pediatric OCD. And, as many parents know, it is quite difficult to find a qualified CBT therapist locally. Thus far, this study has recruited 22 children with OCD. Although the study is not complete, most of those who have completed the treatment have experienced significant improvements in OCD symptoms and have been very satisfied with the treatment and its delivery overall.

Describing another application of advances in technology, Dr. Moritz discussed how text messaging could be used to enhance OCD treatment. Basically, texting can be used as a quick, real-time way to monitor progress as well as to troubleshoot between-session problems that could potentially lead to relapse. She showed how a patient maintained an ERP exercise by receiving support and clarification via text messaging. She also noted how videotaping CBT exercises could assist OCD treatment. For instance, patients can create a video diary showing how they are using CBT in their daily life and where they are struggling. Supporting the saying, "a picture is sometimes worth a thousand words," a video diary can help patients to effectively communicate hard-to-explain OCD symptoms to their treatment team. This can greatly assist therapists in terms of their level of understanding and ability to create better intervention strategies. Dr. Moritz also explained how a video diary can help people with OCD see themselves and their behaviors more realistically and therefore help with awareness, motivation, and self-monitoring. Dr. Moritz additionally spoke about how creating psycho-educational and CBT therapy computer games could improve OCD treatment for children.

Computer-aided programs for OCD (e.g. BTSteps) are another promising area for integrating technology into OCD treatment. CBT treatment can be costly and very time consuming. This technological approach, which offers an interactive method to use CBT for self-help, can possibly address these concerns for appropriate situations. Research on the effectiveness of computer-aided programs for OCD treatment with CBT is growing. It will be interesting to see how people with different OCD symptoms respond to this concept. Another area in which computer-based interactions could benefit those with OCD is called "social networking." An example of a social network for those with OCD is OCDTribe (**www.ocdtribe.com**). Websites such as this provide the opportunity for 24/7 information-sharing and mutual support, something that "in-person" support groups cannot do.

The "proceed with caution" warning about the use of technology in the treatment of OCD has a number of aspects that were highlighted by Dr. Hoffman. It must be recognized that at present the Internet is not a perfectly secure form of communication. Therefore, videoconferencing, text messaging and sharing very personal information in online social networking groups should be conducted with this potential limitation to confidentiality and privacy in mind. Compliance with HIPAA regulations is also of concern in all Internet-based OCD treatments. Also, integrating new technologies into their lives may be a challenge for many people, especially older adults and those with severe financial constraints.

A videoconferencing session was referenced during which, unbeknownst to the therapist at the time, a young adult OCD patient had friends listening in just out of camera range. What else could a webcam miss? The point here is that as valuable as a cyber session might be, it may not be the equivalent of a real-life interaction between patient and clinician. Also, what happens if, during an important time in a videoconferencing exposure therapy session, the Internet connection is lost?

The question of where a videoconference OCD treatment session actually takes place raises another cautionary signal. Is it happening where the clinician is located, where the patient is located, or at some unknown location in cyberspace? The answer to this question has bearing upon insurance reimbursement and also whether the practitioner is providing services within the scope of their state licensure. Such concerns are at the cutting edge of law and mental health services. However, at present, technological change has far outpaced changes in regulatory provisions. The American Psychological Association has yet to set clear professional practice and ethical standards for Internet- and other technology-based treatments.

Although computerized CBT programs can be helpful, they cannot yet replace CBT that is done on an in-person basis. As for virtual reality exposure, the technology is advancing rapidly. However, OCD symptoms have nuances that virtual reality cannot capture. Moreover, no matter how "realistic" virtual reality exposure becomes, many will not benefit because deep down they know it's "not real" and they can always "escape."

Dr. Hoffman raised the concern that perhaps all this technology has the potential to inadvertently dehumanize OCD treatment. After all, can interacting with a computer program, text message, virtual reality scene, or image on a screen really substitute for an empathic human-to-human contact experienced in real life and real time? The quality of OCD treatment may be adversely affected by technology as well. It is important not to let the "bells and whistles" of technological advances detract from the importance of treating the whole person who has OCD (e.g. a person who has a germ phobia and who has a supportive spouse may need a treatment plan with some different strategies than a person who has similar symptoms but is embroiled in severe conflicts with their spouse).

After reading this article, it is possible that both patients and clinicians may have mixed feelings about introducing technology into CBT treatment for OCD. But weighing the pros and cons, the authors of this article suggest re-structuring resistant thinking about introducing technology into OCD treatment strategies as just another opportunity for exposure. In actuality, technology will be increasingly integrated into the health system in general and OCD treatment will be no exception. Therefore, the true challenge before us regarding OCD treatment is not whether to accept technology, but rather to learn how to utilize it wisely and effectively.

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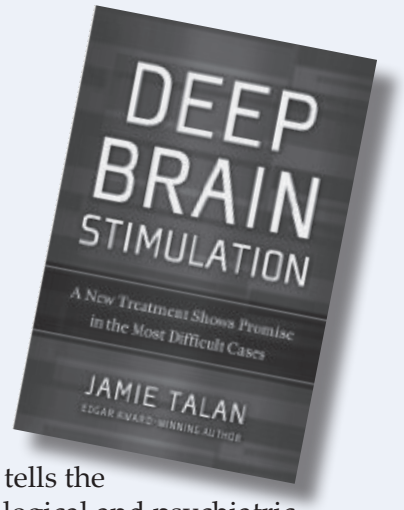
Book Review: Deep Brain Stimulation, by Jamie Talan



Reviewed by Jamie Feusner, M.D.

Jamie Feusner, M.D., 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, and a member of the International OCD Foundation's Scientific Advisory Board.

Deep Brain Stimulation (Dana Press, New York/Washington D.C., 2009), by science writer Jamie Talan, describes a relatively new therapy that involves surgical implantation of electrodes in the brain, similar to a pacemaker. This book tells the story of the development of deep brain stimulation (DBS) as a treatment for neurological and psychiatric disorders such as Parkinson's disease, chronic pain, epilepsy, obsessive-compulsive disorder (OCD), Tourette's and depression. As the author describes, it is a "cautionary tale of successes, failures, and life somewhere in the middle of all this technology." Throughout the book, it alternates between the viewpoints of patients, doctors, and scientists.

The topic of the book is certainly timely and important; the FDA in the past 12 years has approved DBS for the treatment of essential tremor, Parkinson's disease, dystonia, and earlier in 2009 granted Medtronic a "humanitarian device exception" for OCD. This means that it is approved for individuals who have chronic, severe OCD and who do not respond to medication trials. With more and more individuals receiving this treatment, or at least hearing about it as an option, there is likely a desire for a more thorough understanding of this device, how it works, and for whom. The book is comprehensive, accurate, and up to date (aside from the FDA decision for OCD, which may have occurred too recently to make it into the book).

The author does a remarkable job of communicating complex ideas related to brain circuits, diseases, and brain stimulation technology in a way that most readers will understand. The book reads like a story in which the often-colorful characters are the individuals struck with debilitating diseases, the doctors in their quests to help them, and the scientists developing and testing the technology. Readers will be drawn to grasp the details of the neurobiology and treatment techniques so that they will be able to follow the plot of the story.

Jamie Talan's book provides a deeper view of these topics than most of what appears in the popular media having to do with medical illnesses and new technology, which is usually oversimplified to the point of inaccuracy. She nevertheless maintains the perspective of someone not in the scientific field and is able to see the larger ethical contexts. She handles DBS quite objectively by writing about both success stories and failures and by avoiding soap boxing for or against it. In the end, the message she conveys is that DBS can be helpful for those who suffer tremendously and for whom no other treatments have worked, but it is not without significant risk.

This book would be appropriate for those not in the medical field but who desire an understanding of how this technology was developed and for whom it may be effective. In this way, individuals suffering from a brain disorder who may be considering DBS, and family members involved in their treatment decisions, would certainly benefits from its insights and objectivity.

Book Review: Obsessive Compulsive Disorder for Dummies, by Charles Elliot, PhD and Laura Smith, PhD

Reviewed by Deb Osgood-Hynes, PsyD

Deb Osgood-Hynes, PsyD, is a cognitive behavioral psychologist at the Center for Behavioral Health, LLC, in Pembroke, MA. She has over 23 years of experience working with people with OCD and is a member of the International OCD Foundation's Scientific Advisory Board.

Continuing the "For Dummies" book series, authors Charles Elliot, Ph.D. and Laura Smith, Ph.D. offer practical information to help readers understand the nature of OCD and methods of treatment. Whether you are an individual struggling with OCD, a family member or friend of someone with OCD, or a clinician seeking more information, the authors provide a comprehensive review presented in an easy-to-read self-help format. Gentle humor throughout the book combined with bite-size subsections of information within each chapter (highlights, side bars, bullets and case examples) help to pull the reader through the vast extent of information offered.

Part I (The Ins and Outs of OCD) captures the essence of OCD doubts and uncertainty experienced, and covers what is and what is not OCD. What is currently known about the biological basis of OCD is discussed and a review is offered of learning principles which can contribute to an increase of OCD symptoms.

Are you seeking motivation to take the beginning steps? Do you fear change or have a fear of facing your worries? Then Part II (Starting Down the Treatment Path) will help, as it offers ideas to take on the challenge of pursuing cognitive and behavioral treatment and discusses ways people limit their efforts toward symptom reduction. Chapter 6 emphasizes that change is not always smooth or easy. This section also includes a useful discussion on choosing the right professional when seeking OCD treatment and questions to ask when evaluating a mental health professional.

Part III (Overcoming OCD) covers information about cognitive therapy, behavioral therapy (exposure and response prevention), medication treatment and relapse prevention. Specific narratives and exposure and response prevention hierarchy examples are supplied to assist with application of the concepts to the reader's personal needs. Also useful is the concept of "staging a fire drill" to predict times when relapse may occur, with intervention strategies recommended to reduce the likelihood of increased symptoms in the future.

Are you searching for an in-depth review of various OCD subtypes such as checking, just-so OCD, and hoarding, to name a few? If so, then turn to Part IV (Targeting Specific Symptoms of OCD). The importance of this section lies in the variety of ideas offered to create exposure and response prevention (ERP) hierarchy steps. For those with kids or family members with OCD, Part V (Assisting Others with OCD) offers assistance to parents and discusses how family and friends can serve as an OCD coach. Part VI (The Part of the Tens) offers brief creative ideas to continue the treatment journey such as ten quick OCD tricks or ten steps to take after you get better.

The information provided within these chapters is invaluable to those seeking knowledge about OCD. Given the format of the book, it is not necessary to read this book sequentially from front to back cover in order to take advantage of the material within. It is a useful self-help reference that can be opened to almost any section to find tidbits that can be immediately incorporated into symptom reduction efforts.

One of the many strengths of this book is the way in which cognitive therapy interventions are creatively infused throughout the text regardless of chapter. However, a cautionary tip should be provided on when not to use self-talk strategies. For some people who engage in excessive analyzing, productive OCD challenges can shift to unproductive excessive self-reassurance mental rituals performed in an effort to reduce uncomfortable

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(Obsessive Compulsive for Dummies, continued)

doubt and uncertainty generated by an obsession. Additionally, while another positive of this book is its thoroughness of scope, readers seeking a workbook style walk-through of step-by-step strategy application may find it more challenging to sort through the amount of information offered. Chapter 10 provides good fear hierarchy examples with additional forms to assist ERP efforts located in Appendix B. Many more potential ERP ideas (a few in step hierarchy format) are offered in the chapters which target specific symptoms of OCD. Those having difficulty extrapolating from the text to create personal ERP hierarchies will want to seek assistance from a trained mental health professional, as noted by the authors. Finally, while I liked the discussion in Chapter 4 about OCD brain biology as well as the review of selective serotonin reuptake inhibitors in Chapter 11, the book appears to present a slight treatment bias. The chapter on medications did discuss benefits of medication, as well as the benefit of combining medication with cognitive behavioral therapy, however there appeared to be a hesitancy in advocating for psychopharmacological interventions as an important treatment option regardless of OCD severity, as noted by comments such as "most experts in OCD agree that psychological treatment is the preferred choice for most cases of OCD," followed by a section stating medication usefulness for severe OCD, and then a section discussing the risks of medication prior to actually discussing the potential usefulness of medication. Information frequently sought out in treatment and not addressed in this chapter were typical dose ranges for medications, a more detailed description of medication augmenting protocols, and medications for kids versus medications for adults.

Given the extent of good information found within, I would definitely recommend this book to consumers and clinicians seeking information about OCD. The book *OCD for Dummies* is instructive and informative. It stays close to empirically validated treatment strategies. Anyone who reads this book will find themselves more empowered with knowledge about OCD and have numerous useful tools to reduce their OCD symptoms. It is a good resource to have in any OCD information library.

IOCDF Institutional Member Updates

IOCDF Institutional Members are all programs that offer more than traditional outpatient therapy for those who need higher levels of care. We are pleased to announce the addition of two new Institutional Members:

OCD and Anxiety Treatment Center
Program Director: Steven Pence, PhD, LLC
3030 Starkey Blvd., Suite 128
New Port Richey, FL 34655
Phone: (727) 569-2239
Fax: (727) 569-2240
E-mail: **spence@ocdandanxietytreatment.com**
Website: **www.ocdandanxietytreatment.com**

The Lindner Center of Hope
Program Director: Charles Brady, PhD, ABPP
The Lindner Center of Hope
4075 Old Western Row Road
Mason, OH 45040
Phone: (513) 536-0636
Fax: (513) 536-0619
E-mail: **charles.brady@lindnercenter.org**
Website: **www.lindnercenterofhope.org**

Please see the announcements on the next page for other program updates.

(Institutional Member Updates, continued)

FLORIDA

University of South Florida OCD Program adds new faculty members

The University of South Florida OCD program has welcomed two new faculty members to its ranks: Adam Lewin, Ph.D., and Betty Horng, Ph.D. Dr. Lewin received his Ph.D. in clinical psychology at the University of Florida and subsequently completed his residency in clinical psychology and postdoctoral fellowship at UCLA. Lewin has published considerably on OCD and related disorders, and has clinical and research interests on OCD, tic and anxiety spectrum disorders. Dr. Horng also has clinical interests in treating OCD and other primary anxiety, as well as anxiety-related disorders. Dr. Horng received her PhD in Clinical Psychology from Binghamton University and gained extensive clinical experience in treating severe anxiety patients in an intensive outpatient setting during her two-year post doctoral fellowship at the St. Louis Behavioral Medicine Institute. Both Drs. Lewin and Horng will be seeing people with OCD (kids and adults) in the USF program.

MASSACHUSETTS

McLean Hospital Adds Second Residential Program

McLean Hospital has added an additional residential program called Orchard House for patients with mood and anxiety disorders, including OCD. As a result, patients seeking admission to the OCD Institute at McLean will now hopefully face somewhat shorter waiting times to enter the program. Patients still participate in the same OCDI program consisting of extensive ERP and group, individual, and family therapy. Interested program applicants should contact Admissions Coordinator Tricia Jamiol at (617) 855-3371 or **tjamiol@mclean.harvard.edu**.

RESEARCH NEWS

Exposure and Response Prevention for OCD: Should it be conducted in or out of the office?

Karen Rowa, Ph.D., C.Psych.

Karen Rowa, Ph.D., is a psychologist at the Anxiety Treatment and Research Centre at St. Joseph's Healthcare in Hamilton, Ontario, Canada and an Assistant Professor in the Department of Psychiatry and Behavioural Neurosciences at McMaster University. She specializes in the assessment and treatment of anxiety disorders, with an emphasis on Obsessive Compulsive Disorder. Dr. Rowa is active in teaching, supervision, research, and clinical work.

Although exposure with response prevention (ERP) is an effective treatment for Obsessive Compulsive Disorder (OCD), not everyone who receives ERP fully responds to this treatment. Further, a large number of people drop out of treatment, do not start treatment, or cannot generalize their gains to their everyday life. For this reason, researchers are studying different ways of offering this treatment in order to maximize results for people with OCD. One of the ways that might help people complete and generalize exposure exercises is for therapists to offer sessions outside of their office. Our centre conducted a study which compared offering treatment in the therapist's office versus offering treatment at the client's home or in another environment where the client experiences OCD symptoms.

There are a number of reasons to suspect that offering ERP outside of the therapist's office might provide greater benefit to the client than standard ERP within the office setting. For example, some situations or triggers cannot be replicated in a hospital or office environment or are not especially fear-provoking once brought into the office. For example, an individual who has obsessions that the food she has prepared is not cooked properly may not be able to bring food into sessions or cook in the therapist's office. Or a client who has aggressive urges to hurt his children may not find using sharp objects in the therapist's office nearly as frightening as doing this in his own home. Further, the gains made in traditional office-based ERP may not easily generalize to other environments without some home-based sessions, and certain exposure exercises might be too anxiety-provoking for people to try on their own at home.

(continued on p. 20)

RESEARCH NEWS

(Exposure and Response Prevention for OCD, continued)

On the other hand, traditional ERP offered in an office setting might be just as effective as sessions conducted outside the office for the majority of clients. If this is the case, therapists can feel confident that the majority of sessions can be effectively completed in the office, with the use of home or outside the office sessions offered on a case-by-case basis when needed.

No studies have compared ERP offered within vs. outside of the office for a large group of people diagnosed with OCD. Through a research grant from the Obsessive Compulsive Foundation (now known as the International OCD Foundation), our centre conducted a study that compared 14 sessions of ERP offered in the therapist's office or offered in the client's home or another environment where OCD symptoms occurred. This study was published in 2007 [Rowa, K., Antony, M.M., Summerfeldt, L.J., Purdon, C., Young, L., & Swinson, R.P. (2007). Office-based vs. home-based behavioral treatment for obsessive compulsive disorder: A preliminary study. *Behaviour Research and Therapy*, 45, 1883-1892]. Each session was 90 minutes long, and the majority of sessions (12) were conducted twice-weekly. Initial sessions for all participants were completed in the therapist's office, where the therapist provided education about ERP and developed an exposure hierarchy with the client. Sessions 3 though 14 were conducted either in the therapist's office for the "office" group or outside the office in the "home" group. Participants were randomly assigned to either treatment condition, which resulted in a broad range of OCD symptom presentations in each treatment group. A total of 28 people participated in this study, with 14 receiving treatment in the therapist's office and 14 receiving treatment wherever their symptoms most routinely occurred.

Before ERP began, we conducted assessments of OCD symptom severity, symptoms of depression, and the degree to which OCD symptoms interfere with people's lives. These questions were repeated after treatment was completed, and again at 3- and 6-month follow up appointments.

Results of this study suggested that sessions offered in the therapist's office and sessions offered outside the office did equally well in providing relief from OCD symptoms, impairment from these symptoms, and symptoms of depression. These improvements lasted through the 6 month follow-up appointments. This was somewhat surprising to our team, given that the therapists conducting office sessions were asked to be very strict about remaining in their office for all sessions. For example, at our hospital-based clinic, therapists routinely help clients conduct exposure exercises in public washrooms or other public areas of the hospital. During the duration of this study, therapists working in the "office" condition were asked to refrain from leaving their office at all, not even using the public hospital washrooms for exposures. Therefore, even under very strict instructions to remain in the office, clients did very well with ERP. Anecdotally, therapists and clients in the office condition became very creative to create helpful exposure scenarios within the office setting. For example, clients brought contaminants into the office setting, they used small appliances in the office without checking them, and they exposed themselves to aggressive thoughts of harming loved ones while holding pictures of their loved ones.

It is very encouraging that office-based ERP works just as well as home-based ERP for the majority of participants. Out of office treatment is more challenging on a practical level (e.g., more therapist travel time which means home-based ERP is less cost-effective and therapists can see fewer clients) as well as on a personal level for some clients (some people in our study felt slightly uncomfortable allowing a therapist into their home). Therefore, home or out of office sessions can be reserved for special circumstances where a client cannot leave his or her home, or where the therapist and client mutually agree that home sessions are necessary or helpful for maximizing ERP (e.g., for clients who hoard or who cannot do exposure exercises at home on their own).

Research Participants Sought

Has Anyone Ever Called You a Packrat?

- Have people ever commented about the amount of clutter in your home?
- Is your home so cluttered that you have trouble using your rooms or furniture?
- Do you have difficulty throwing things away, even when you don't need them?

The Boston University School of Social Work is conducting a study on the nature of compulsive hoarding. The study is open to adults aged 18 and over who meet study criteria. Participants must live within a 45 minute radius of Boston, Massachusetts. For more information, please email Gabe Gruner at **ggruner@bu.edu** or call (617) 353-9125.

Do You Pull Out Your Hair?

Dr. Nancy Keuthen at Massachusetts General Hospital is conducting a non-medication treatment study of Trichotillomania. You may be eligible to participate if you are at least 18 years of age, have been pulling out your hair for the past year, and are not receiving any current treatment for this problem. You may receive up to $200 compensation upon completion of study participation. For further information, please call Martha Falkenstein at (617) 643-6204.

Children and Adolescents who are Pack Rats: An Exploratory Study to Examine Compulsive Hoarding in Children and Adolescents

The aim of this study is to develop a better understanding of the onset and the clinical features of compulsive hoarding in children and adolescents. According to the limited research available on compulsive hoarding, onset of compulsive hoarding begins in childhood, and hoarding behaviors become more severe with age. Treatment with adults has demonstrated that compulsive hoarding is more resistant to traditional interventions such as medication and exposure and response prevention therapy. Very little is currently known about children and adolescents who struggle with this condition. Therefore, we are currently conducting a cross-sectional research study for information that will build our knowledge base to improve intervention strategies.

Your child must be between the ages of 8-18 and have some symptoms of obsessive compulsive behaviors with hoarding. All participants will be administered a screening instrument to determine eligibility. Both the child/adolescent and one parent must be willing to participate in telephone interviews.

If eligible, participants will participate in data collection through telephone survey. The participating parent will be interviewed first by phone. Parents will complete a demographic questionnaire, an inventory, and a timeline about their child/adolescent's behaviors. Children/adolescents will complete two inventories about their obsessive compulsive and hoarding behaviors. It is expected that the parent and child/adolescent interviews will take approximately 20-30 minutes each. Participant families will be compensated with a $20 gift card to WalMart.

To participate in this study or for further information, please contact David Dia, PhD, LCSW, CCBT at the University of Tennessee at (901) 448-4431, or email him at **ddia@utk.edu**. This study is approved by the University IRB.

Concerned with your appearance?

Do you dislike the way any part(s) of your body look? Do you think about your appearance for more than 1 hour per day? Do you engage in behaviors to try to hide, fix, or check your appearance? Do your appearance concerns cause you anxiety, shame or sadness? Do these concerns cause problems for you with school, your family or your friends? If you answered "yes" to any of these questions and live in the Boston area, we may be able to help. Massachusetts General Hospital is conducting a no-cost clinical trial with children and adolescents (ages 10 to 17 years) who are worried about how they look. Those qualified will receive a diagnostic evaluation and psychological treatment (CBT) at no cost. If you are interested in the possibility of an evaluation and participation in the research study, please contact Martha Falkenstein at The Body Dysmorphic Disorder Clinic at Massachusetts General Hospital. Call (617) 643-6204 or email **bdd@partners.org**.

Do You or Does Your Child Have OCD?

An Open-Label Exploratory Investigation of D-Cycloserine

(continued on p. 22)

RESEARCH NEWS

(Research Participants Sought, continued)

Augmentation to Cognitive Behavioral Therapy with Exposure and Response Prevention for Adults and Adolescents Diagnosed with Obsessive Compulsive Disorder - A Feasibility Study
Principal Investigators: Moira Rynn, M.D.; Blair Simpson, M.D., Ph.D.
NYSPI IRB Protocol: #5828
Diagnostic Groups: Obsessive Compulsive Disorder (OCD)
Age Range: 12-65 (inclusive)
Gender: Male and Female
Language Requirements: English-speaking only

Inclusion Criteria:
- Able to understand and follow study procedures
- Adolescents and adults ages of 12-65 who are in good physical health
- All sexually active participants of childbearing potential who are using a medically acceptable form of birth control
- If receiving SRI medication, participants should already be on it for at least 12 weeks
- If receiving other psychotropic medication, participants should already be on it for at least 4 weeks

Exclusion Criteria:
- Medical conditions that would conflict with participation
- Psychiatric disorders or symptoms that would conflict with participation
- Receiving psychotherapy
- Females who are pregnant or nursing, or who plan to become pregnant

Brief Summary of Study Procedures:
The purpose of this research study is to see if a medication called D-Cycloserine (DCS) is safe and helpful to enhance the outcome of cognitive behavioral therapy with exposure and response prevention (E/RP therapy) for adolescents and adults with obsessive compulsive disorder (OCD). The study will last up to 7 weeks, and will consist of a screening period of up to two weeks and a treatment period of up to 5 weeks that consists of twice weekly 60-minute E/RP sessions. Patients may receive up to 50 mg of DCS after some of the E/RP sessions.

Study Recruitment Ending Date: Ongoing
Contact Information: Telephone: (212) 543-0266
New York State Psychiatric Institute (NYSPI) at 1051 Riverside Drive, New York, NY 10032

Do you have a child diagnosed with Obsessive Compulsive Disorder (OCD) or who displays OCD symptoms?
We are looking for parents to participate in a study examining treatment history of OCD. Your responses may help in improving treatment and access to qualified professionals who can provide effective treatments to children with OCD. This is a completely anonymous survey. Please go to the link below to participate in the study.

https://www.surveymonkey.com/s.aspx?sm=eQ7Jyrg_2bmrW5DYdMXblryw_3d_3d

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Compulsive Hair Pulling?
Researchers at Stanford are investigating whether the medication aripiprazole, currently used for other psychiatric conditions, might be helpful in the treatment of compulsive hair pulling (Trichotillomania). The study involves three visits to Stanford over eight weeks. All subjects will receive study medication. There will be no placebo group.

In order to participate in this research study, you must:

- Be between 18 – 65 years old
- Not have a diagnosis of Obsessive-Compulsive Disorder, Bipolar Disorder or Schizophrenia
- Not have a current problem with alcohol or drugs

There is no cost to participate in this research study, and you will receive free medication for the duration of the trial.

For more information, please contact Dr. White at the Stanford Department of Psychiatry (650) 725-5598 or **mpwhite@stanford.edu**.

For questions regarding participants' research rights, call 1-866-680-2906.

Does your Child have Obsessive-Compulsive Disorder?
Researchers at the Feinstein Institute for Medical Research - North Shore/ Long Island Jewish Hospital are conducting a research study on the neurobiology and genetics of Obsessive Compulsive Disorder (OCD) to improve treatment methods and identify biomarkers for this disorder. This study does not provide treatment.

To participate, a child must be:
- Between the ages of 8-17
- Not taking certain medications, including serotonin reuptake inhibitors, for at least 4 weeks

The study involves diagnostic interviews with the child and one parent, some clinical measures,

neuropsychological testing, an MRI exam, and an optional DNA component done through saliva collection. MRI is a safe, non-invasive neuroimaging technique (with no risk of ionizing radiation) that allows us to learn more about brain structure and function. There is no cost to you and your child will be compensated for his or her time. Participation can generally be completed in two testing sessions and scheduling is very flexible. Participants will receive up to $270 compensation.

If you are interested or have questions, please contact:

Patricia Gruner, Ph.D.
Psychiatry Research
The Zucker Hillside Hospital
75-59 263rd Street
Glen Oaks, NY 11004
Tel: (718) 470-8609
Fax: (718) 343-1659
pgruner@nshs.edu

Affiliate Updates

Our regional affiliates carry out the mission of the International OCD Foundation through programs at the local community level. All of our affiliates are non-profit organizations that are run entirely by dedicated volunteers. If you would like to find help in your community or would like to volunteer in grassroots efforts to raise awareness and funds locally, please contact one of our affiliates below.

CALIFORNIA

OCD San Francisco Bay Area (OCDSFBA) Helps to Spread Awareness

In early October 2009, OCDSFBA's co-founder and former President Scott Granet, LCSW, recorded a five-minute interview at Comcast Studios in San Francisco. In the interview, Scott discusses the definition of OCD, the point at which obsessive-compulsive behavior becomes a disorder, and the available treatments for it. To watch this interview, please go to the following page: **http://www.youtube.com/iocdf.**

On Saturday, October 17, 2009, the OCDSFBA held its first speaker and panel discussion in support of national OCD Awareness Week (Oct. 12-18). Peter Weinstein, the OCDSFBA President, kicked off the event with an overview of the affiliate's mission and activities. The keynote speaker was Scott Granet, former President and current Board member of the affiliate, and an OCD therapist in private practice. The event also featured a panel of three individuals with OCD and two family members who spoke about their personal experience with OCD and the impact of OCD on family members and their lives.

MASSACHUSETTS

OCD Boston Announces 2010 Lecture Series Dates

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

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

Sponsored by OCD Boston, an Affiliate of the International OCD Foundation

March 2, 2010	Coping Skills for People with OCD	Thröstur Björgvinsson, PhD McLean Hospital/Harvard Medical School
April 6, 2010	The Role of Guilt in OCD	Leslie Shapiro, LICSW McLean Hospital OCD Institute
May 4, 2010	The Journey of Recovery: What Will Life Be Like Without OCD?	Szu-Hui Lee, PhD McLean Hospital OCD Institute

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

(continued on p. 24)

FROM THE AFFILIATES

(Affiliate Updates, continued)

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

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

PENNSYLVANIA

OCD Western PA Vice President Elaine Davis Chosen as Western PA Jefferson Award Winner

Elaine Davis, PhD, Vice President of OCD Western PA (OCD/WPA) was recently chosen as one of the 50 Western PA 2009 Jefferson Award winners by a group of community representatives. The program was named after founding father Thomas Jefferson and annually honors unsung heroes who perform outstanding public service in their community. Elaine's story of helping those who live with OCD was highlighted in the Pittsburgh Post-Gazette, and she will be honored in February 2010 at an elegant reception at which she will receive the bronze Jefferson Award medallion, which was commissioned by the Franklin Mint.

Elaine has been a volunteer for the OCD/WPA since 2000 and currently serves as Vice President, along with chairing several committees. Elaine volunteers an average of 20 hours per month. She constantly strives to help OCD sufferers find treatment and to educate the community about this disorder.

Forming Affiliates

In addition to our current affiliates, there are also individuals or groups looking to start new affiliates. If you are interested in helping to start an affiliate in one of the areas listed below, please call or email the contact person for your state.

If there is not a current or forming affiliate in your area and you are interested in starting one in your community, please contact the IOCDF Program Director, Mike Spigler, at **mspigler@ocfoundation.org**.

GEORGIA

Reverend Charles Paige
Email: **georgiaocd@gmail.com**
Phone: (678) 701-3379

or

Christy Hall, Psy.D.
Email: **christyhall78@hotmail.com**
Phone: (678) 612-3418

MARYLAND, VIRGINIA, and WASHINGTON, D.C.

Charles Mansueto, Ph.D.
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or

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TEXAS

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

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