INTERNATIONAL OCD FOUNDATION

OCD Newsletter

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OCD and Related Disorders in the New DSM and What it Means for You

by Jeff Szymanski, PhD, and Carly Bourne

The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) is the "bible" of mental disorders used by mental health professionals to accurately diagnose mental health issues. First published in 1952, the *DSM* has been updated 3 times since then to include a wealth of new information as our understanding of mental health and disorders has evolved and grown over the years. In April 2013, the 5th edition of the *DSM* will be published by the American Psychiatric Association, culminating a 14-year planning and development process that included input from over 1,500 mental health and medical experts from around the world.

The IOCDF recently had the opportunity to interview Katharine Phillips, MD, the Chair of the Anxiety, Obsessive Compulsive Spectrum of Post-Traumatic and Dissociative Disorders Work Group for the *DSM-5*, to learn more about the updates to this new edition of the *DSM*. In the following excerpt of that interview, Dr. Jeff Szymanski talks with Dr. Phillips about some changes to how OCD and related disorders are classified in the new *DSM*, and what the implications of those changes will be on OCD diagnosis and treatment.

JS: Thank you for the opportunity to talk to you about your work on the DSM-5. Can you tell us a little about your background and your involvement with the DSM?

KP: I am Director of the Body Dysmorphic Disorder Program and Director of Research for Adult Psychiatry at Rhode Island

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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.

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DISCLAIMER:

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

What's (Who's) New at the IOCDF Office?

In 2008, the International OCD Foundation changed its name from the Obsessive Compulsive Foundation, and moved to Boston, MA. The organization also hired a completely new staff to take the organization to the next level. A key hire at this time was Michael Spigler, MCHES, as the new Program Director. For the past four and a half years, Michael has spearheaded many important initiatives as well as expanding the Foundation's program offerings for people with OCD and professionals alike. For example, attendance at the Annual Conference practically doubled under Michael's watch. Michael is very well known to many in the OCD and related disorders community and has had a profound impact in helping to advance the mission of the IOCDF. He now has the chance to work with another non-profit organization in the Washington DC area, where he's originally from. We are extremely sad to see Michael go, but we are also happy for him as he embarks on this new journey. We know that he will bring the same talents, innovation, and sense of humor to this new endeavor.

With Michael vacating the position of Program Director, we are excited to announce the promotion of Marissa Keegan. Marissa has been with the IOCDF for the past two and half years and has shown tremendous dedication, leadership, and skill in her role working under Michael in the program department. She has skillfully led the evolution of the Behavior Therapy Training Institute (BTTI) along with Clinical Director, Dr. Alec Pollard — allowing us to run five of these trainings each year, and even planning a new Pediatric BTTI for 2013. We are in the process of hiring someone to take over Marissa's role as Assistant Program Director, and look forward to announcing this new addition to our staff soon.

Speaking of transitions, Pamela Lowy — who has been with the IOCDF for over three years — has been promoted to the Director of Operations and Finance as her role has expanded with the growth of the Foundation. Pam has been critical to helping build a strong and lasting infrastructure in the Foundation and we are very grateful for her dedication and hard work.

Another new addition to our staff is Grace Riley as our new Administrative Assistant. Grace's background includes work as a Haiti Development Fund Intern through the William J. Clinton Foundation and as a case liaison helping to find temporary housing for homeless and at-risk youth. I'm sure many of you will be talking with Grace when you contact the Foundation! We are happy to have her on board.

Last, but not least, a belated welcome to Carly Bourne, our Director of Communications. Carly started with the IOCDF last May and hit the ground running at the Annual Conference. You might have seen many of the updates on our website, more activity on Facebook and Twitter, and upgrades to this newsletter because of Carly. Look for some other big changes to the Foundation as she has even more in store for all of us in the coming year!

-Jeff Szymanski, PhD
Executive Director of the IOCDF

Letter from the President

On average, it can take 14–17 years from the time someone with OCD first notices symptoms to the time that person gains access to effective treatment. For all of us in the OCD community, this is simply unacceptable. Since its inception, the International OCD Foundation has worked diligently to change this reality by funding OCD research, developing quality and innovative programming for people affected by OCD, and educating mental health and medical professionals and the community about this condition.

In the field of psychology and psychiatry, clinicians use the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) to diagnose mental health conditions. The *DSM* essentially serves as a roadmap for mental health professionals — it contains information and criteria used to identify psychological disorders which helps determine the most effective treatment plan. In May, the American Psychiatric Association will publish the fifth edition of the *DSM* and there will be important changes in it for the OCD community. In short, OCD will now be listed in a separate category, called OCD and Related Disorders, instead of being listed under Anxiety Disorders. In addition, Hoarding Disorder, Excoriation (Skin Picking) Disorder, Body Dysmorphic Disorder, and Trichotillomania (hair pulling disorder) will all be listed as separate disorders within the OCD and Related Disorders category and there will be updated information in the criteria to help with diagnoses.

I believe these changes will be extremely helpful to the OCD and related disorders community. As a clinician myself, I believe the DSM has actually "caught up" to what many of us had already recognized. For example, the IOCDF had already been referring to "OCD and related disorders" for over two decades. Because of these updates, it is likely that more clinicians will now recognize and diagnose OCD and related disorders and that the correct diagnosis will lead to more appropriate treatment for those suffering from these disorders.

In the past, because Hoarding and Skin Picking were not recognized as separate disorders, the conditions were often diagnosed inaccurately as OCD or, worse yet, dismissed altogether as something trivial. Additionally, because diagnostic criteria, specifically related to "insight" (or lack thereof) in people with OCD, was too narrow in previous versions of the *DSM*, some people with little or no insight into their symptoms were incorrectly diagnosed with schizophrenia. Misdiagnosis can prevent access to effective treatment, leading to unnecessary additional suffering, hopelessness, family strain, and financial loss. We are hopeful that the changes in the new DSM will reduce the time it takes to get an accurate diagnosis and treatment.

As you will see from Dr. Jeff Szymanski's interview with Dr. Katharine Phillips, these important changes were driven by years of research. Without it, there wouldn't have been enough evidence to support the recommendations made by the working group to add new disorders, re-classify others, and to change diagnostic criteria. In a time when mental health research funding is sparse, and even more so for research on OCD and related and disorders, the IOCDF is proud to be a partner in research, having funded almost 100 projects totaling close to 3 million dollars. We are currently accepting proposals for new research grants focused on OCD and related disorders and will continue to share the results from this important work with our members and the community.

While actions like revisions to the *DSM* represent important steps forward, there is still much work to be done to increase awareness and education about OCD in the professional community and in the general public. Please help to support the IOCDF on this important mission. We will not rest until people are diagnosed swiftly and accurately and there are enough qualified, well-trained professionals to provide all of those in need with effective treatment.

Sincerely,

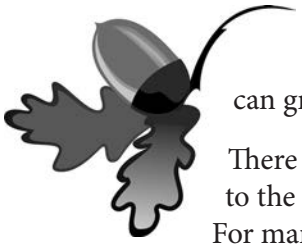
Denise Egan Stack, LMHC
President
IOCDF Board of Directors

FROM THE FOUNDATION

Leave a Lasting Impact – Legacy Giving at the IOCDF

By Jeff Smith, Director of Development

"From a tiny acorn grows the mighty oak."



Like the acorn in this old maxim, regardless of the size of a bequest, it can grow into a lasting legacy.

There are many reasons that people donate to the International OCD Foundation. For many, it was a personal and positive experience with the Foundation; perhaps they called the office and found help through a provider listed in our treatment provider database. Or, they attended the Annual Conference and discovered that they were part of a larger community and found an important support network. Others choose to donate to the IOCDF to remember a friend or relative and to help others less fortunate, or because of a desire to give back to the community (and the extra bonus of a tax benefit!).

Whatever the reason, a gift to the IOCDF helps the Foundation continue to provide important resources for people living with OCD, their families, treatment providers, and others seeking to learn more about the disorder.

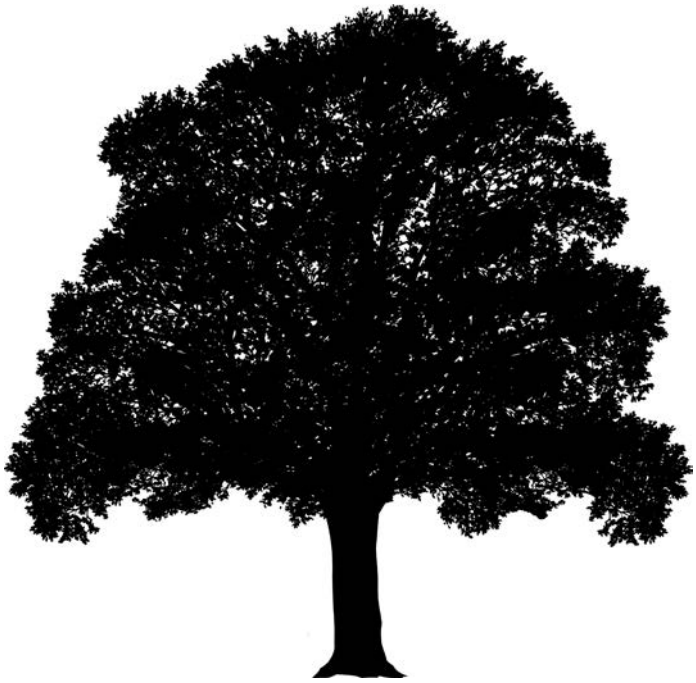
Donors have a wide range of opportunities to make a difference in the lives of others through planned giving. This can mean an outright gift of cash or appreciated property; a deferred gift arrangement, such as a charitable bequest; or designating the IOCDF as a beneficiary of a life insurance policy. Sometimes donors choose to use a combination of gifts carefully planned to help support a program that is meaningful to them, such as the Behavior Therapy Training Institute (BTTI).

One of the easiest ways to leave a legacy and support the IOCDF in a truly significant way is to include us in your will. There is no immediate cost to you, you can change it at any time, and you will be making a critical impact on the IOCDF's ability to serve the OCD community well into the future.

The IOCDF is pleased to announce the launch of The Legacy Society. The Society honors individuals who have made a provision for a future gift to the IOCDF through a bequest in their will or other arrangement such as a retirement plan or life insurance beneficiary designation. The Legacy Society affords the Foundation the opportunity to extend our warm appreciation to those who notify us of their thoughtful gift intentions. There are no dues or other obligations, but Society members will receive a certificate of membership and a small memento, as well as recognition in our annual donor listing, thus inspiring others to join the Society.

If you have included the IOCDF in your estate plan, please let us know! If you join the Society before the end of 2013, you will be listed as a Charter Member, unless you wish for your participation to remain anonymous.

I hope you will consider becoming a member of The Legacy Society. Taking this small step now will have an impact on future generations for years to come. Please contact Jeff Smith, Director of Development if you would like to notify the IOCDF of your intent to include us in your estate plan, or if you would like further information about planned giving opportunities. You can reach Jeff at jsmith@ocfoundation.org or by calling 617-973-5801, ext. 24.



Donor Profile: Margaret Sisson

The term "grassroots" is often used to denote any kind of effort that derives most of its power and reason for being from people on the ground, in the community. While these efforts may seem small, they can also be very powerful. Whether it's efforts to build awareness or raise money, grassroots advocacy can have a big affect on the ability of organizations like the International OCD Foundation to succeed in our mission. Margaret Sisson is one advocate who has found innovative ways to help the IOCDF through creating her own fundraising event, in addition to volunteering with the Foundation.

"Never doubt that a small group of thoughtful, committed people can change the world. Indeed, it is the only thing that ever has."

- Margaret Mead

Margaret's involvement with the IOCDF began after reading the book, *When in Doubt, Make Belief*, by IOCDF Spokesperson Jeff Bell. Margaret was especially motivated by the forward of Jeff's book, written by IOCDF Board Member Dr. Michael Jenike. Dr. Jenike spoke about Jeff Bell's determination to focus on two goals: purpose and service to others. After reading Jeff's book, Margaret determined that she would do the same.

Margaret draws her inspiration from her son, who was diagnosed with OCD at the age of 12. After receiving effective treatment, and undergoing a long journey — Margaret's son is now 23 and is attending college as a Psychology major and living on his own for the first time.

In July of 2012, Margaret and her son attended the 19th Annual OCD Conference in Chicago. Margaret says: "Not only did we benefit from the number of sessions we attended, but we met a lot of people whose journey was similar to ours. We felt a real sense of community." It was at the conference that Margaret learned the 2013 Conference was going to be in her own backyard in Atlanta, GA, and she wanted to get involved.

She decided to start her grassroots efforts by hosting a fundraiser for the IOCDF. Realizing that most of her friends were leading busy lives and might not have the time to attend a fundraiser, especially during the holiday season, Margaret came up with a fun and effective way to raise money: a "Wine Raffle". Margaret sent a letter to her friends asking them to donate a $15 or $20 bottle of their favorite wine and deliver it to her home. Her goal was to collect 24 bottles of good wine that she could then auction via a raffle. Margaret sold raffle tickets to her friends, family and colleagues. 1 ticket for $10, 3 tickets for $20, and 6 tickets for $35. Once Margaret had collected two cases of wine, she drew two winning tickets! Two lucky winners received a case of wine each just before the holidays. They could enjoy it themselves or give it as gifts. Margaret ended up raising $500 for the IOCDF!

It is faithful supporters like Margaret who make the work of the Foundation possible.

Have you held a grassroots fundraising event for the IOCDF? Are you participating in a run, a bike ride, or other event to raise money for the IOCDF? If so, please share your story with us… we want to learn more about our members and your efforts to support the foundation. Please contact Jeff Smith at jsmith@ocfoundation.org and share your story today.

FROM THE FOUNDATION

DSM-V Updates (Continued from cover)

Hospital, and a Professor of Psychiatry and Human Behavior at Brown University. For the *DSM*, I was Chair of the Anxiety, Obsessive Compulsive Spectrum of Post-Traumatic and Dissociative Disorders Work Group. I was also a member of the *DSM-5* Task Force. So, I was quite involved with *DSM-5*, and especially with the disorders that my work group was responsible for.

JS: It's my understanding that Obsessive Compulsive Disorder, OCD, is being moved out from under the Anxiety Disorder section, into its own category for the DSM-5. Is that accurate? And if so, what went into that decision?

KP: Yes. OCD is being put into a separate category — it's a new category of Obsessive Compulsive and Related Disorders — and that is along with several other disorders: Body Dysmorphic Disorder; Hoarding Disorder; Excoriation (skin picking) Disorder; and Trichotillomania (hair pulling disorder). And a lot went into this decision. I think I'll start by saying that recommendations for *DSM-5*, and decisions for *DSM-5*, more generally, were very evidence-based. They were based upon available, empirical data. So scientific data really drove these decisions when that data was available. And when it wasn't, we considered clinical utility, meaning, "How useful is this proposed change to patients and clinicians?"

So, regarding this particular change, we very carefully reviewed the scientific literature on the relatedness of OCD to other disorders, such as Body Dysmorphic Disorder, and we considered a range of what are called "validators." So, for example, "How similar are these disorders to one another in terms of their symptoms? In terms of their course of illness? Do they have elevated rates of co-occurring with one another? Do these disorders tend to run in families? Do they have shared biomarkers?"

We then compared disorders in terms of a broad array of shared characteristics, and we actually published a literature review on this particular issue, in *Depression and Anxiety*, a couple of years ago. The evidence offered really strong support for creating this category of Obsessive Compulsive and Related Disorders in *DSM-5* and for classifying certain other disorders in this category. It's worth mentioning that this concept of a category of disorders that are related to OCD has generally been accepted by this field for several decades — over the years it's been called "Obsessive Compulsive Spectrum Disorders." And there's been a lot of scientific evidence that's accumulated over the past several decades to support the inclusion of this category.

JS: So OCD got pulled out from the Anxiety Disorders category into it's own category. Can you tell us what was the thinking there? Is anxiety still considered the core component of OCD?

KP: Well, of course, OCD does have some shared features with the Anxiety Disorders — and Body Dysmorphic Disorder does as well, especially with Social Anxiety Disorder. But overall, it was thought to make more sense to have a separate category with Obsessive Compulsive and Related Disorders, though, Obsessive Compulsive and Related Disorders will directly follow the Anxiety Disorders in *DSM-5*. And the ordering of the chapters is going to have a lot more meaning than it did in *DSM-4*, with the most important organizing principle for the order of chapters in *DSM-5* being the relatedness of disorders to one another. So, Obsessive Compulsive and Related Disorders are purposely, directly following Anxiety Disorders to convey to the field that, "Yes, Obsessive Compulsive and Related Disorders are separated out from Anxiety Disorders, but they immediately follow Anxiety Disorders, which means that at least some of the disorders in Obsessive Compulsive and Related Disorders are closely related to Anxiety Disorders, and I would say, primarily, Obsessive Compulsive Disorder and Body Dysmorphic Disorder."

JS: Excellent. And so, what are the changes to the diagnostic criteria for OCD, if any? And, what were the thoughts that went into that?

KP: The two most notable changes are the addition of two new specifiers — well, a modification of one specifier and the addition of a new specifier. A specifier for "insight" is being changed and expanded from *DSM-4*; and then there will be a new specifier for "past or current tic disorder." Now, in a way, these aren't big changes, because the specifiers do not effect who gets the diagnosis. A specifier is used once a person receives the

diagnosis of OCD to further characterize the nature of the person's symptoms.

For the insight specifier, we put a lot of thought into [that change]. The *DSM-4* definition of OCD has one specifier — having poor insight. And we recommended — again, based on the scientific literature — that this specifier be expanded to include a broader range of insight specifiers. So, not just having poor insight; but there'll be a category for "good" or "fair insight," "poor insight," and "absent insight/delusional OCD beliefs." And the purpose of this expansion of the insight options, is to clarify that insight varies along a continuum in OCD: from good insight to absent insight.

In *DSM-4*, there was a problem in that people with "absent insight" — in other words, people who were completely convinced that their OCD belief was true and that if they didn't check the house or the locks, or the stove thirty times, the house would definitely burn down — could receive a diagnosis of a psychotic disorder. And the concern of the work group members was that, in our clinical experience, we have seen some of those people being misdiagnosed as having schizophrenia, and then not getting the right treatment. By clarifying that this is part of OCD, we hope that this will lead to better treatment of these patients, that they won't be inaccurately diagnosed as having schizophrenia, for example, or another psychotic disorder. So, we think this will fix a problem that was present in *DSM-4*.

We also recommended a corresponding criterion change: in *DSM-4*, the person had to recognize that their obsessions or compulsions are excessive or unreasonable, which is related to the insight issue, right? But, there's now a fair amount of data that's been collected over quite a few years, indicating that there's a range of insight levels in OCD. Not all patients have good insight. A fair proportion have only fair insight. They're not sure, for example, whether the house will burn down, you know, if they don't check the stove over and over again. They think it might possibly burn down. And this is OCD. It's not uncommon in OCD to have poor insight. So, again, the purpose of this is to clarify that OCD does span this range of insight. We hope that leads, you know, to more accurate diagnosis and better treatment. And I should mention, this insight specifier will also be included, for Body Dysmorphic Disorder, and for Hoarding Disorder, two of the other disorders that will be included in this new category of Obsessive Compulsive and Related Disorders.

And the new specifier in the *DSM-5* for OCD is a tic specifier that designates a past or current tic disorder. There's a lot of scientific evidence to support this. The tic-related variant of OCD is highly familial, it tends to be early onset, tends to affect males more than females. And, perhaps most importantly, individuals who have a co-morbid tic disorder may benefit more from the addition of a neuroleptic, also known as an anti-psychotic, to an SSRI, if an SSRI alone does not sufficiently reduce symptoms. I think other changes to OCD were fairly minimal.

Another change to the criteria for OCD was in the definition of "obsession". The word "impulse" is used in *DSM-4*; that will be changed to "urge" in *DSM-5*, to try to minimize confusion with an Impulse Control Disorder. Although the category of Impulse Control Disorders won't exist in *DSM-5*, but, just to minimize misdiagnosis of OCD as something like, kleptomania, or gambling disorder, for example. So, there's a few other minor changes for OCD, but not many to the criteria, themselves.

JS: I am curious: compulsions are to minimize or reduce anxiety, and we do know that people engage in avoidance as a way of keeping anxiety from even getting started. Did "avoidance" get kind of underscored or highlighted in the criteria?

KP: We certainly thought a lot about it. It was a quite conservative process and there really had to be a LOT of scientific evidence to support a change to the criteria in *DSM-5*. And I haven't mentioned this yet, but the work group wrote huge amounts of documents summarizing the scientific evidence, in addition to the literature reviews that we published in journals, such as *Depression and Anxiety*. And there were multiple layers of review by various committees. We just felt overall that the evidence to support the addition of a criterion was not quite sufficient for OCD. The diagnostic criteria, you know,

(Continued on next page)

DSM-V Updates (Continued from page 7)

can't cover all aspects of all disorders, but there are a lot of associated features that are very important and those are highlighted in the text, and "avoidance" is one of those.

JS: So, what do you think are some of the implications of these changes to the OCD criteria?

KP: As I mentioned before, I think the insight specifier has positive implications in the sense that, patients with absent insight, or so-called delusional OCD beliefs, will hopefully get diagnosed appropriately with OCD. Now, we're only talking about 2-4% of OCD patients who have absent insight or "Delusional OCD Beliefs." But, we want to minimize the mis-diagnosis a psychotic disorder of schizophrenia in these patients, and we've all seen this in our clinical experience.

Other possible clinical implications are that patients with poor insight may need more motivational interviewing to participate in treatment and to motivate them to engage in treatment. Sometimes patients with poorer insight think, "Well, maybe I don't really have a psychiatric problem, maybe my belief is really true." And they may need more of what we refer to as "motivational interviewing" or "motivational interventions" of some sort to engage in treatment.

The *DSM* is primarily for clinicians, but it's also a manual for researchers, and we hope that researchers will focus more on insight as a predictor of treatment response to cognitive behavioral strategies. For example, Atypical Anti-psychotics have been shown to be a useful addition to an SSRI, but I don't think we know yet if they are more helpful for patients with poor insight, or absent insight. So, we hope that this increased focus on insight will be helpful to researchers to investigate if the level of insight predicts a response to psycho-social interventions for OCD.

JS: I've also heard that Hoarding Disorder and Skin Picking Disorder have been added to the new DSM and that these disorders will be listed in the OCD category. Can you talk a little bit about what went into that decision?

KP: Research has been done on Hoarding Disorder for several decades, so there's a substantial amount of scientific literature. It's also a prevalent disorder that affects somewhere between 2 and 5% of the population. I think as all clinicians who've seen these patients know, it can be a very severe disorder and there can be resulting legal problems — difficulties not only for the hoarder, but for family members and significant others. Most of these people do not actually meet diagnostic criteria for OCD, and don't endorse other clinically significant OCD symptoms. So there wasn't a very helpful or appropriate diagnosis for them in *DSM-4*. By including Hoarding as a separate but related disorder to OCD, we really hope this will lead to better treatment for these patients. There are important differences between Hoarding and OCD, across a whole number of "validators" including how patients respond to treatment.

In terms of Skin Picking Disorder, the formal name in *DSM-5* will be "Excoriation (Skin Picking) Disorder." And, again, there's a growing body of data emphasizing the clinical importance of this disorder, and Skin Picking was not adequately covered by any existing disorder in *DSM-4*. It's also fairly prevalent, with somewhere between 1 and 5% of the population having this disorder. And it can be quite severe — patients can have serious medical consequences, such as infections and skin lesions from repetitive picking, scarring, and sometimes notable physical disfigurement.

You know, one thing I should mention is, we got a tremendous amount of input from the field throughout the entire *DSM-5* process. I mention this, because there was a tremendous amount of support for the inclusion of [Hoarding and Skin Picking] Disorders in DSM-5. And that support was very broad-based: it came from researchers, it came from clinicians; it came from family members; from sufferers of these disorders; and from the public at large. So we were very pleased that these disorders were approved for inclusion in DSM-5.

JS: There is also a change to how Trichotillomania is presented in the DSM-5, is that correct?

KP: Yes, in *DSM-4* Trichotillomania was considered an Impulse Control Disorder, and was classified as such. In *DSM-5*, it will be moving to Obsessive Compulsive and Related Disorders, because the available literature suggests that it is more closely related to OCD than to

other Impulse Control Disorders, such as Intermittent Explosive Disorder, Pyromania, or Kleptomania. The name also has a small change, now including "hair pulling disorder" in parentheses after Trichotillomania, just to clarify what the disorder is referring to. There are also some minor changes to the Trichotillomania criterion from *DSM-4*, which refers to tension before pulling, and gratification after pulling. This has been replaced with language that refers to attempts to stop or decrease hair pulling. The reason being that the *DSM-4* criterion didn't apply to all patients with clinically significant hair pulling.

JS: Can you tell us why including a new disorder is so important? Does defining a new disorder help to improve treatment?

KP: I think it helps with recognition, for one thing. If clinically important symptoms are not identified in *DSM-5,* it's somewhat less likely that clinicians are going to ask patients about those symptoms, or that clinicians are going to be familiar with the syndrome. So I think the first step is more accurate identification of the disorder. And the *DSM-5* facilitates that.

The hope is that it also prevents misidentification of a disorder as a different disorder! Hoarding is a good example of that. If it's diagnosed as OCD, then you apply OCD treatments, which may not work quite as well as a more hoarding-focused treatment. So by having a disorder in the *DSM-5*, we hope it will lead clinicians to recognize the disorder, ask patients about the disorder, and that the patients will bring those symptoms to the attention of clinicians if they have them. And then, clinicians can implement treatments that are more specifically focused on that disorder, and are shown to be helpful for that disorder. ○

You can also learn more about the DSM-5 online at: www.dsm5.org

FROM THE FRONTLINES

Snowy White Mittens

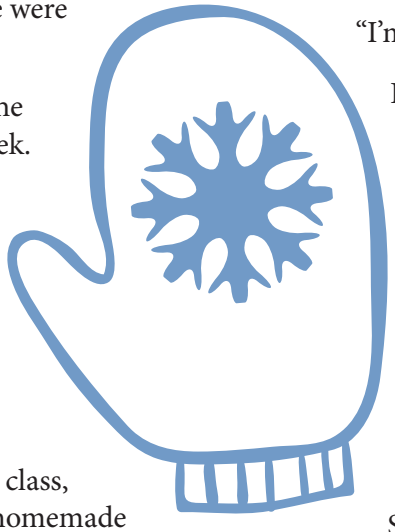
by Meghan Fussman

My kids ate breakfast in the car this morning.

My daughter was throwing away a Pop Tart wrapper and a milk carton in the school bathroom on her way to her class. She turned around and looked at me with wide eyes and said, "I threw away my gloves by accident!"

"Oh, no..." I said.

Normally, I wouldn't have given it a second thought. Gloves are cheap, and this was a bathroom trashcan. But these were not just any gloves. These were her snowy white mittens.



Moriah's teacher read Jan Brett's story, The Mitten, to her kindergarten class last week. The story is about a child who looses a mitten in the forest. While it is lost, animals crawl inside one by one to stay warm. At one point, there is everything from a squirrel to a bear inside it. Ultimately, they leave, but there is something strange about the mitten when the child finds it later... it is very large. After reading the story to her class, the teacher presented each child with a homemade pair of soft, felty, lined, snowy white mittens like the ones in the book. Moriah was in love with them.

Standing there, looking into my daughter's face, my mind raced trying to figure out what to do, me versus OCD.

They are just gloves. We can buy more.

No, they aren't, they are snowy white mittens.

This is a bathroom trash can.

It's first thing in the morning, there's hardly anything in it...

I've seen people throw diapers in there, and paper towels that they've used for bloody noses or when their hands were bleeding. I've thrown tampons away in bathroom trash cans.

It's first thing in the morning... They change the bags every night.

Kids touch the faucets with bleeding hands...

You could probably get the gloves without touching anything. They have probably not touched anything...

But what if....

I have to talk to my son's teacher before school starts! I don't have time for this! I know they are special to her, but I'll buy her new gloves... She'll be disappointed, but she'll forget.

"I'm really sorry this happened Mo." I hug her.

Her eyes look sad. She might want to cry, but turns to go into class. I give her her backpack and another hug, "I'm really sorry about this."

She looks O.K. "She'll be O.K.," I tell myself.

"DANG IT!" I say out loud as I walk my son to class.

"What?" he asks.

She really likes those gloves..." I say, "Let's get you to class. I'll think about it..."

I talk to his teacher, and hug him good-bye.

"Have a great day!" I say to the teacher.

"I better go dig my daughter's gloves out of the bathroom trashcan. She dropped them in there by accident on the way in... Or decide if it's worth it..."

The teacher grimaces, "Maybe, depending on how full it is."

As I walked back to the bathroom, I know what I have to do. It's worth it because she loves them and she is worth it.

But is saving something material worth getting AIDS or some other terminal illness? How will she feel if that happens and I die? But what are the chances of that, and how will she feel if I don't?

Stop thinking about it. Do it!

Walk to the bathroom. Pull a plastic grocery bag out of my pocket that I stashed there on the way into the school. Set it on the stool the kids use to wash their hands. Think about the urine and feces that has likely been tracked on it from the stalls. Peer into the can. I know I can get one of them without touching anything else. Think about taking off my leather jacket in case I touch anything. It can't be washed. Decide to leave it on. Reach in and get the first glove. Put it in the bag. Peer in again. The other is lower. Tip the trashcan gently with my other hand, enough to help me reach better without moving other trash onto the glove. Reach in and get it. Not sure if my coat touched the side. Oh well. Wash my hands. Wonder if I washed under my nails. Only let myself wash them once. Look at the bag. Did the gloves touch the parts that will be on the outside when I close it? Don't know. Oh, well... Tie it closed and get ready to leave. I will wash the gloves and surprise Mo with them at the end of the day. Won't she be excited!?!

She looked so sad...

I walk back to Moriah's classroom. She is at a little table, doing a math sheet. Class has not yet officially started. "I finished, teacher!" she calls out, not noticing me walk in.

I walk up to her and give her a hug. I whisper in her ear, "I got your snowy white mittens out of the trash can, because you are more important than OCD."

She looks at me, nodding her head up and down, her cheeks flushed. I walk out to my car, and drive home.

I feel happy, and as I drive, my thought's drift to the question that I had asked myself more than a week ago, "Why do I feel that my wants and needs are not important as what my OCD wants?"

The answer has brought up a flood of memories, and along with them, feelings of sorrow and shame that have been rooted in my soul.

I almost left the snowy white mittens in the trashcan today, hoping my daughter would forget. Maybe she would have, but the seeds would have been planted — seeds of my failures, her resentment — seeds that would gradually grow like vines around her spirit. Today, I plucked those seeds back out of the dirt when I pulled her gloves out of the trashcan.

In fighting OCD, I know that I shouldn't have washed my hands at all, and I should have let her wear the gloves without washing them. Nonetheless, I did what was most important. I stopped my OCD from taking more from my daughter than it already has.

I made her more important than my fear, and I made sure she knew that.

Now accepting submissions from Kids and teens:

We want to hear from you! Share your art and creative writing with other kids and teens with OCD in the OCD Newsletter.

Poems, short stories, essays, drawings, paintings, and photography all accepted.

Email your submissions to editor@ocfoundation.org.

THERAPY COMMUNITY

Computer, Web, and Smartphone-Based Self-Help Programs for OCD

by Bradley C. Riemann, PhD, & Rachel C. Leonard, PhD

Dr. Bradley Riemann is the Clinical Director of the OCD Center and CBT Services at Rogers Memorial Hospital. He is also Chair of the Clinical Advisory Committee and a member of the Scientific Advisory Board of the IOCDF. Dr. Rachel C. Leonard is a full-time psychologist at Rogers Memorial Hospital in Oconomowoc, Wisconsin. She specializes in cognitive-behavioral therapy approaches for the treatment of anxiety disorders and depression.

New technologies have paved the way for a wide variety of mobile treatment options for OCD, including smartphone-based applications (aka "apps"), and internet and computer-based software programs. These apps and programs have the advantage of being widely accessible and, in some cases, can provide lower cost alternatives to traditional therapy. In this article, we attempt to provide a basic overview of some of these programs. None of our comments should be viewed as a critique or an endorsement of any of these products.

OCD Challenge is an internet-based program developed by the Peace of Mind Foundation. OCD Challenge is an on-line behavioral "self-help website" that is based on the principles of Exposure and Response Prevention (ERP), one of the most effective treatment options for OCD. The OCD Challenge program was developed with input and commentary from leaders in the field of ERP. According to the website, this program takes approximately eight to twelve weeks to complete and moves the user through three modules. The first module, Assessment, requires users to complete various questionnaires to assess their own OCD symptoms. In the second module, Gaining Awareness, users learn the results of these assessments, including identification of their specific obsessions and compulsions. This module also explains the basics of ERP, and how it works. During this module, an "exposure hierarchy" is created, ranking each obsession or compulsion by order of severity based on the user's assessment results. This hierarchy lists various exposure activities for the user to try without engaging in rituals, with the most anxiety-producing activities ordered towards the end of the hierarchy, so that the user begins with simpler exposure activities and gradually progresses towards the more difficult challenges. The final module, Intervention, involves the user working through the exposure hierarchy. As the user completes more and more of their hierarchy, they move up the "OCD Mountain" shown on the screen. When all items on the hierarchy are completed, the user reaches the top of the mountain and the program concludes. A research study of the effectiveness of the OCD Challenge program is currently being conducted, with early results expected later in 2013. **OCD Challenge is available free of charge at www.ocdchallenge.com.**

Another internet-based program is **BT Steps**. Like OCD Challenge, BT Steps incorporates the principles of ERP. BT Steps was developed by OCD researchers John H. Greist, MD; Isaac M. Marks, MD; and Lee Baer, PhD, roughly 20 years ago as a telephone-based treatment program. Today, it is available as an internet-based program, but the concept remains the same. In BT Steps, users progress through six different steps, starting with learning more about OCD and how it affects them. In the second step, users are provided with information on Cognitive Behavioral Therapy (CBT) and ERP, so that they can determine if exposure treatment is right for them. Following this, users are guided through the process of identifying triggers across different OCD symptom dimensions. Then, detailed information on how to complete an exposure trial is provided, and users are prompted to complete their first exposure session. In the fifth step, users work to refine their exposure technique. The final step focuses on maintenance of gains that users have made throughout the program. Research studies of the original phone-based BT Steps found the program to be effective in lowering OCD symptoms, when compared with relaxation techniques, though BT Steps was not as effective as traditional clinician-supervised ERP. The new online version of BT Steps is currently being evaluated through a clinical trial funded by the National Institute of Mental Health. **For more information about the program, and to find out when BT Steps will be available to the general public, please contact Revere Greist at rgreist@centerforpsychconsulting.com or by telephone at (608) 556-0766.**

Cognitive Retraining Technologies has developed several software programs for treating anxiety, including a program aimed specifically at fear of germs and contamination, using a method known as Attention Retraining. This technique is based on the premise that individuals with OCD have been found to focus their attention on threat cues (i.e., triggers) related to their fears of contamination. Attention Retraining teaches users to retrain their attention away from these types of cues (for example, germs and contamination)

to cues that they don't fear, called "neutral cues." This method has been supported by research conducted by Dr. Nader Amir. The Fear of Contamination and Germs Relief Program, as well as other anxiety relief programs, is available for download for $139.99 from www.managingyouranxiety.com.

In addition to these computer-based self-help programs, there are also several other smartphone apps available:

Decontamination OCD Retrainer, is a free smartphone app launched by Neurosail, which also uses Attention Retraining in a similar fashion to the software program described above. This app is available for free on the iTunes store for Apple mobile devices.

Live OCD Free by Pocket Therapist, LLC, is an ERP-based smartphone app developed by Kristen Mulcahy, PhD. Within this app, users develop their own exposure hierarchy and set reminders to complete exposure trials. Following each exposure trial, users record their anxiety. Users can also record the number of times per day they resist or give in to urges to ritualize. The app also asks users to rate their anxiety on a weekly basis. Users receive progress reports regarding their exposures, engagement in rituals, and weekly anxiety ratings and these progress reports can then be emailed to a treatment provider if applicable. This app includes separate versions for adults and children. In the child version, users fight the "Worry Wizard" and are taught that giving in to the requests of the Worry Wizard will make the Wizard, and their worry or anxiety, stronger. The wording within this version is also more child-friendly; however, the basic concepts remain the same across both versions. There is also an online forum provided for additional support at www.liveOCDfree.com. The LiveOCDFree app is currently available for $79.99 through the iTunes store for Apple mobile devices.

The **Anxiety Coach** app by the Mayo Clinic was developed by Stephen Whiteside, PhD, and Jonathan Abramowitz, PhD. Within this app, users start by completing a short test to assess the severity of their symptoms. They then create a personal treatment plan that targets their specific fears or worries. To assist with the development of the treatment plan, the app allows users to browse over 500 activities designed to assist with symptoms of OCD, panic attacks, social anxiety, specific fears, separation anxiety, general worries, and anxiety related to trauma. Users can also add in their own hierarchy items. The Anxiety Coach prompts users to track their anxiety before each exposure trial and then in two-minute intervals throughout the exposure trial until they reach a 50% reduction in anxiety. When this happens, they can then choose whether to check the item off of their list or keep it for continued practice. Anxiety Coach allows users to record and view their progress over time. If the user's anxiety is more severe, the app provides tools to help users learn when and how to seek professional assistance. Anxiety Coach costs $4.99 and is available for Apple mobile devices through the iTunes store.

iCounselor OCD is an app designed to teach users skills to help them with OCD symptoms. Users are asked to rate the frequency and strength of OCD-related thoughts. They are then presented with various skills sets. The first involves calming activities for the user to perform, such as progressive muscle relaxation, breathing techniques, imagery, and focusing on the present moment. The second skills set involves working to change OCD-related thoughts, and the third skills set works to help users resist engaging in rituals through either completely resisting the ritual or through other techniques such as delaying or changing the ritual. After using the different skills, users are prompted to rate their OCD symptom severity again to determine whether the skills were helpful. If the user has not experienced a significant decrease in anxiety, they are given the opportunity to practice the skills again. iCounselor OCD is available for Apple mobile devices through the iTunes store for $0.99.

Finally, **OCD Manager**, launched by Gareth Jones with content developed by Cheryll Meikle, MSc, is an app based on CBT and rational emotive behavior therapy. This app includes information on OCD as well as audio recordings, such as mindfulness of breathing and a "body scan" mindfulness exercise. OCD Manager also includes a "challenges" section in which users can choose from pre-programmed exposure activities, or add in their own. It also includes a section on "rational thinking" that guides users through the process of challenging some of their irrational beliefs. OCD Manager is available through the iTunes store for $19.99.

Computer-assisted and smartphone-based self-help programs such as these are likely to become much more common with time. Most current programs utilize CBT principles that have been found to be effective in treating OCD. Others, however, are using newer treatment methods such as Attention Retraining. Users of any of these programs may find them effective — indeed some have research support backing their use. However, for some it may be more appropriate to use these programs in conjunction with ongoing treatment with a CBT provider.

THERAPY COMMUNITY

Institutional Member Updates

THE AUSTIN CENTER FOR THE TREATMENT OF OCD

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AustinOCD, now celebrating its 10th year, is pleased to announce that Misti Nicholson, PsyD, is now fully licensed to practice psychology in the state of Texas. In addition to working with children and families in a clinical setting, Dr. Nicholson also provides training for teachers and school staff on recognizing OCD in the classroom.

NEUROBEHAVIORAL INSTITUTE

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NBI offers evidence-based treatments for OCD, including Cognitive Behavioral Therapy (CBT) and Exposure and Response Prevention (ERP). Our Intensive Outpatient Programs (IOP) for OCD and related conditions is specifically designed to meet the needs of each individual patient. Typically, in the IOP patients are seen for two to five sessions a day, up to five days a weeks, for 2-8 weeks. OCD Support Groups are offered monthly both for children and adults.

NBI is also continuing the growth of both our neuropsychological testing department and our affiliated educational consulting practice, Academic Options. If you are interested in finding out more about our services or in scheduling an appointment, please contact our office at (954) 217-1757 or visit our websites www.nbiweston.com and www.academic-options.com.

OCD INSTITUTE AT MCLEAN HOSPITAL

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www.mclean.harvard.edu/patient/adult/ocd.php

OCDI would like to introduce the Office of Clinical Assessment and Research (OCAR, pronounced "o-care"). The formation of OCAR was a natural progression of the work done by many dedicated clinical researchers who have made research at the OCDI possible since it's inception in 1997. The mission of OCAR is to develop a center of excellence specializing in naturalistic, clinical research that will directly improve the effectiveness of treatment for patients with OCD and related disorders. This will be accomplished through program evaluation, clinical assessment (before, during, and after treatment), and clinical trials at the OCDI, as well as through collaboration with colleagues outside the OCDI. OCAR's research model is unique among research labs by harnessing the creativity and expertise of frontline clinicians to address the most challenging questions affecting the patients we treat every day. OCAR supplies the infrastructure and technical expertise to create a natural synergy with full-time clinicians, who are motivated to do research by their desire improve the lives of patients.

OCAR is located on the third floor of the North Belknap Building on McLean's campus. OCAR staff: Dr. Jason Elias, Director of Psychological Services and Clinical Research; Dr. Jesse Crosby, Clinical Research Fellow; Christina Gironda, Research Coordinator; and Christine Andre, Senior Research Assistant; Dr. Jason Krompinger, Research Associate.

OBSESSIVE-COMPULSIVE DISORDER CENTER AT ROGERS MEMORIAL HOSPITAL

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www.rogersocd.org

Empowering children and teens in all aspects of their care means identifying strengths and providing targeted strategies for a more productive life. Rogers Memorial Hospital's new stand-alone, Child & Adolescent Centers building was intentionally designed to facilitate our patient-centered approach to care in a warm, comfortable atmosphere.

The new 33,140-square-foot building now houses Rogers' two nationally recognized programs for children and adolescents under one roof. Each program has its own floor featuring spacious day rooms, family consult rooms and improved accessibility. The Child Center (children, 8-13) and Adolescent Center (adolescents, 12-17) are under the direction of board-certified child and adolescent psychiatrists who practice full-time at Rogers Memorial Hospital.

While each program has open spaces to promote positive socialization and engagement, they are balanced with private treatment rooms for individual therapy, family therapy, and visits. This balance enhances patients' connection to their surroundings, which is critical to engaging them in the treatment and recovery process. The 27,500-square-foot experiential therapy center includes a gymnasium, art therapy studio, recreation room, fitness area and classroom.

RESEARCH NEWS

OCD and ADHD: Dual Diagnosis, Misdiagnosis and the Cognitive 'Cost' of Obsessions

by Amitai Abramovitch, PhD, & Andrew Mittelman

Dr. Amitai Abramovitch is a neuropsychologist and a Research Fellow at the OCD and Related Disorders Program at Massachusetts General Hospital and the Department of Psychiatry at Harvard Medical School. Dr. Abramovitch can be reached at aabramovitch@partners.org.

Andrew Mittelman is a Research Coordinator at the OCD and Related Disorders Program at Massachusetts General Hospital. He can be reached at amittelman@partners.org.

Both obsessive compulsive disorder (OCD) and attention-deficit hyperactivity disorder (ADHD) are considered fairly common and serious neuropsychiatric disorders. To the untrained eye, some of the symptoms associated with attention and concentration can appear remarkably similar, especially in children and adolescents. However, ADHD and OCD are notably different in terms of brain activity and their clinical presentation. ADHD is considered be an externalizing disorder, meaning it affects how people outwardly relate to their environment. Individuals with ADHD may exhibit inattention, lack of impulse control, and risky behaviors. OCD, on the other hand, is characterized as an internalizing disorder, meaning individuals with OCD respond to anxiety producing environments by turning inward. Individuals with OCD exhibit frequent obsessive and/or compulsive thoughts and behaviors. In addition, generally speaking, people with OCD tend to demonstrate a more inhibited temperament and tend to avoid risky or potentially harmful situations. Furthermore, individuals diagnosed with OCD are overly concerned with the consequences of their actions and tend to not act impulsively. Not surprisingly, people with OCD exhibit unusually low rates of novelty seeking behavior and cigarette smoking.

Considerable evidence has suggested that ADHD and OCD are characterized by abnormal brain activity in the same neural circuit. Specifically, both conditions exhibit opposite patterns of brain activity in the frontostriatal system[1], the segment of the brain responsible for higher order motor, cognitive, and behavioral functions. However, the similarities between OCD and ADHD are limited to only which part of the brain is affected; patients with OCD exhibit significantly increased activity (hypermetabolism) in the frontostriatal circuits, meaning this part of the brain is overactive in people with OCD, while patients with ADHD exhibit decreased activity (hypometabolism), meaning this part of the brain is less active in people with ADHD.

While the disorders are associated with very different pattern sof brain activity, the resulting cognitive effects are actually similar, especially in executive functions[2] such as response inhibition, planning, task switching, working memory, and decision making. Sufferers of both OCD and ADHD have consistently and significantly underperformed in tests of executive functions.

Some research has suggested that OCD and Obsessive Compulsive Spectrum Disorders fall upon a compulsive-impulsive continuum. In other words, there exists a gradient of disorders ranging from behavioral impulsivity to compulsivity. OCD appears to lie at one end of this spectrum, while ADHD exists at the other. This is surprising, considering that over 35 studies have reported that an average of 21% of children and 8.5% of adults with OCD actually have ADHD as well.

This begs the question: can one person be both impulsive and careful—be both a risk taker and avoid risks—and exhibit opposite patterns of brain activity at the same time? As a secondary question, if this indeed is possible, how can we account for the significant decrease in reported comorbidity rates in adulthood? Is it the case that two thirds of the children diagnosed with both disorders become cured from one of the conditions? These two questions were at the focus of our research into the association between ADHD and OCD.

(Continued on next page)

1. Including the orbitofrontal, dorsolateral prefrontal, and anterior cingulate cortices, in addition to the striatal structures and thalamus.
2. Executive function is a blanket term for the higher level brain processes that regulate, control, and manage other brain processes, such as planning, working memory, attention, problem solving, verbal reasoning, inhibition, mental flexibility, and task switching.

OCD and ADHD (Continued from page 15)

In order to answer the first question, we examined our hypothesis that different mechanisms in OCD and ADHD may result in similar cognitive impairments, in other words, though the disorders are associated with very different patterns of brain activity, they may result in the same effects on a person's cognitive functioning. This hypothesis is in line with other research suggesting that very different disorders are characterized by impairments in executive functions, although they may differ in patterns of brain activity and clinical picture. For example, despite very different symptoms, post-traumatic stress disorder, major depressive disorder, panic disorder, schizophrenia, and bipolar disorder are all characterized by impairments in executive functions and abnormal patterns of brain activity. In addition, across conditions, trait and state anxiety has been associated with cognitive impairments. Thus, we have proposed an "Executive Overload model of OCD."

The Executive Overload model suggests that sufferers of OCD experience an "overflow" of obsessive thoughts. This overflow (which was found to correlate with increased frontostriatal brain activity) results in an overload upon the executive system, which is reflected in executive impairment, resulting in changes to a person's behaviors and abilities. In general, anxiety has been known to put strain on the executive system, and we argue that obsessions may be similar to anxiety in regards to their associated cognitive 'cost'. Specifically, individuals with OCD are demonstrating deficits that we believe are actually caused by the symptoms themselves.

A good analogy for the Executive Overload model of OCD would be the RAM memory on a personal computer. The more software programs that a computer has operating in the background, the less processing power is available to support complex computations (think of Microsoft Word crashing because you have too many other programs open). In OCD, a person may perform a certain task while at the same time experiencing a surge of intrusive thoughts such as "am I doing this right?" or "did I make a mistake?" etc. Thus, the more obsessive intrusive thoughts that an individual experiences in a given moment, the fewer resources would be available for other tasks (such as listening to a teacher in class, or concentrating during a business a meeting), especially complex ones. In other words, cognitive impairments in OCD are largely state-dependent; thus, our model predicts that treating and reducing OCD symptoms ought to be accompanied by an improvement of executive functioning.

This progression has indeed been observed in patients undergoing OCD treatment, where in conjunction with clinical improvement, CBT resulted in decreased abnormal brain activity and improvement in cognitive symptoms. Our direct comparison of ADHD and OCD groups yielded an association between Obsessive Compulsive (OC) symptoms and executive function impairments only within the OCD group, and not in the control or ADHD groups. We observed that deficient performance on tests of executive functions was correlated with the presence of OC symptoms but only within the OCD group. In other words, for people with OCD, an increase in reported obsessive/compulsive thoughts and behaviors also meant a decrease in performance on executive function tests such as ability to suppress responses.

However, within the ADHD group, more OC symptoms were actually correlated with better performance in tests of executive functions — one hypothesis has suggested that this may be because individuals with ADHD who also exhibit OC traits are better organized and attentive to details than individuals with ADHD who exhibit no OC symptoms.

In a second study, we examined the nature of ADHD symptoms throughout the lifespan. We noted that ADHD symptoms were correlated between childhood and adulthood in the ADHD and control groups, but not within the OCD group. This second study suggested that some attention problems in children and adolescents may actually stem from OCD symptoms and are not ADHD related.

The second question regarding the co-occurrence between OCD and ADHD remains to be answered. Review of the literature suggests that two major findings are clearly observable. First, research reporting prevalence rates of ADHD-OCD co-occurrence exhibits significant inconsistency with reports ranging from 0% to 59% of individuals with OCD diagnosed with concomitant ADHD. Whereas research suggests that one out of five children with OCD has co-occurring ADHD, only one out

of every 12 adults with OCD has ADHD. So what happens to half of the children with OCD who initially diagnosed with ADHD as well; does it disappear in adulthood? The answer appears to be both "yes" and "no." It appears that preadolescent children with OCD go through a slower process of brain development in which their pattern of brain activity and associated symptoms may appear to fit the symptomatic description of ADHD. However, through adolescence, this arrested development begins to abate, as ADHD-like symptoms dissipate and brain activity changes to fit the adult patterns observed in adult OCD. Furthermore, we suspect that a full-blown dual diagnosis of ADHD and OCD in adults is, in fact, rather rare and is usually associated with a mediating condition (notably chronic tic disorder or Tourette Syndrome).

The ways that neuropsychological impairments manifest in a person's behavior are universal. For example, a deficit in attention, regardless of the cause or condition, may cause an individual to appear as if she is not listening when spoken to directly (which is one of the DSM criteria for ADHD). In the light of deficits in attention and executive functions seen in both OCD and ADHD, it is easy to see how a clinician might potentially misdiagnose one condition as the other. In fact, chances of misdiagnosis may even be higher in children and young adolescents, for whom diagnosis relies heavily on informants such as parents or teachers.

Consider the example of a child with OCD who sits in class obsessing over a stain on her sleeve. Frequently preoccupied by an overflow of obsessive-intrusive thoughts, this child cannot be attentive in class and would possibly receive increasingly lower grades. In turn, the teacher might perceive this student as inattentive, and would report to the counselor and parents that the student may have ADHD. In an attempt to help the child focus more in class, a clinician may prescribe stimulant medication (such as Ritalin) after misdiagnosing the child with ADHD. Several studies suggest that stimulant therapy may exacerbate obsessive-compulsive thoughts and behaviors or even induce them. Instead of improving, the misdiagnosed child would likely even deteriorate in condition. In fact, this may be intuitively explained; stimulant therapy increases frontostriatal brain activity, which is generally reduced in ADHD. In OCD, a disorder characterized by increased activity (which is correlated with symptom severity), stimulant medication will continue to activate an already hyperactive brain (specifically the frontostriatal system), potentially resulting in immediate exacerbation of symptoms. Another possible explanation once suggested in the scientific literature, is that under the influence of stimulants, individuals with OCD may experience improved attention toward obsessive thoughts, potentially resulting in an increase in obsessions and an increase in compensatory compulsive rituals.

IMPLICATIONS FOR PRACTICE

In light of the potential pitfalls of misdiagnosis, we recommend that clinicians examine two major diagnostic factors that may aid in establishing a more accurate diagnosis. First, clinicians ought to note the presence or absence of clinically significant levels of impulsivity and risk taking. Unlike those with ADHD, from adolescence, people with OCD are very rarely impulsive and do not exhibit risk-taking behavior. This is especially true when OCD is the patient's primary disorder. It is worth noting that 75% of all individuals diagnosed with ADHD are diagnosed with the impulsive/hyperactive (combined) type, associated with significant impulsive behavior, and ruling out the 'pure' inattentive type is more of a challenge. The second diagnostic marker is the ability to perform accurate and repetitive rituals governed by very specific and complex rules, something that people with ADHD will generally struggle with. In fact, attention to detail and the ability to strictly follow attention-demanding tasks are characteristic impairments of ADHD and are considered clinical diagnostic criteria.

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RESEARCH NEWS

Research Spotlight: Journal of Obsessive Compulsive and Related Disorders

This column highlights abstracts of interesting new research and articles about OCD and related disorders from the first scientific journal dedicated solely to OCD: the *Journal of Obsessive Compulsive and Related Disorders*, edited by IOCDF Scientific and Clinical Advisory Board Member, Jonathan S. Abramowitz, PhD.

Delivering exposure and ritual prevention for obsessive–compulsive disorder via videoconference: Clinical considerations and recommendations

By Elizabeth M. Goetter, James D. Herbert, Evan M. Forman, Erica K. Yuen, Marina Gershkovich , Lisa H. Glassman, Stephanie Rabin, & Stephanie P. Goldstein

Available online 19 January 2013
http://dx.doi.org/10.1016/j.jocrd.2013.01.003

Exposure and ritual prevention (ERP) has been shown to be effective for treating obsessive–compulsive disorder (OCD), but many people with OCD are not able to access this specialized, evidence-based mental health treatment. Internet-mediated technologies, e.g., videoconferencing, represent a way to increase the availability of evidence-based treatments such as ERP, but given that OCD is a complex disorder requiring a nuanced treatment approach, clinicians attempting to implement ERP remotely should appreciate not only the advantages but also the challenges associated with treating OCD from a distance. Using a case example, we describe this treatment method and discuss relevant clinical considerations.

Lutheran clergy members' responses to scrupulosity: The effects of moral thought–action fusion and liberal vs. conservative denomination

by Brett J. Deacon, Amanda M. Vincent, & Annie R. Zhang

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http://dx.doi.org/10.1016/j.jocrd.2012.12.003

OCD with primary religious themes, also known as scrupulosity, is an understudied problem that poses unique clinical challenges owing to the potential conflicts between the requirements of exposure and response prevention and adherence to religious law. Although previous discussions have highlighted the potential role of clergy members in the maintenance and treatment of this problem, empirical research has not examined religious authorities' attitudes and behaviors toward scrupulous parishioners. The present study investigated moral thought–action fusion, view of God, and responses to a hypothetical parishioner with scrupulosity among 70 clergy members affiliated with liberal or conservative denominations of the Lutheran church. Pastors affiliated with the more conservative denomination evidenced higher moral thought–action fusion, belief in a micromanaging God, and responses to a scrupulous parishioner that risk reinforcing compulsive rituals and the fear of sin (e.g., admonitions of God's expectations for purity in thought and deed, advising regular confession of sinful thoughts). Moral thought–action fusion fully mediated denominational differences in potentially problematic responses to a scrupulous parishioner. Implications for collaborative efforts between mental health professionals and clergy members to improve the prevention and management of scrupulosity are discussed.

Preliminary assessment of Obsessive-Compulsive Spectrum Disorder Scales for DSM-5

by R.T. LeBeau, E. Mischel, H.B. Simpson, D. Mataix-Cols, K.A. Phillips, D.J. Stein, & M.G. Craske

Available online 25 January 2013
http://dx.doi.org/10.1016/j.jocrd.2013.01.005

There will be several changes to the diagnosis of obsessive-compulsive and related disorders (OCRDs) in *DSM-5*. Several disorders, including body dysmorphic disorder (BDD), hoarding disorder (HD), trichotillomania (hair-pulling disorder) (TTM), and excoriation (skin-picking) disorder (SPD), will be included alongside obsessive compulsive disorder (OCD) in a distinct diagnostic category of OCRDs. Also, dimensional assessments of psychopathology will be included to supplement traditional categorical diagnoses. The DSM-5 Subworkgroup on Obsessive-Compulsive Spectrum Disorders developed a set of brief self-rated scales for BDD, HD, TTM, and SPD that are consistent in content and structure and reflect *DSM-5* criteria and can be used by clinicians to help generate a dimensional severity rating for the disorders. In the present paper, we discuss the scales' creation and examine their psychometric properties in a large non-clinical sample (n=296). The scales each demonstrated a single factor structure, strong internal consistency (α=.80–.89), convergent validity (rs=.74–.92), and significantly higher total scores in individuals who indicated the presence of the respective disorder's core symptom on a binary diagnostic screener (Cohen's d=0.57–2.18). The results provide support for further evaluation of these scales in clinical samples and take an important step toward the integration of standardized dimensional measurement into *DSM-5*.

Research Participants Sought

The IOCDF is not affiliated with any of the following studies, but we provide this information as a service to our members. The studies are listed by alphabetically by state, with multi-site studies (open to many geographic areas) at the end.

If you are a researcher who would like to include your research listing in the OCD Newsletter, please contact Marissa Keegan at mkeegan@ocfoundation.org.

ILLINOIS

Skin Picking Study

Do you pick your skin? Is it causing problems? Does it feel out of control? We at the University of Chicago are currently seeking volunteers for a drug study using a supplement for skin picking.

Participation in either study requires several visits to our Chicago study center. As a result, those interested in participating must live within the Chicago metro area and must be at least 18 years of age.

If interested in either of these studies, please contact:

Katherine Derbyshire, BS, Psychiatric Research Specialist
University of Chicago, Department of Psychiatry
Addictive, Compulsive, and Impulsive Disorders Research Program
Tel: 773-702-9066
Email: kderbyshire@uchicago.edu

Jon Grant, MD, JD, MPH
University of Chicago, Department of Psychiatry

RHODE ISLAND

Neuropsychology Comparison Group for OCD Study

Principal Investigator: Benjamin Greenberg MD, PhD
Butler Hospital
365 Blackstone Blvd.
Providence, RI 02906

Butler Hospital is conducting a separate nonsurgical study examining the relationship between the brain and behavior in OCD. This study consists of a clinical interview and testing on two occasions within a year. Participants in this study will be compensated for their time.

For more information, contact rmcmahon@butler.org or call (401) 455-6594.

MULTI-SITE

Mount Sinai OCD Study

You are invited to participate in this multi-center, randomized, double-blind, parallel-group, placebo-controlled study that will evaluate the efficacy and safety of a new investigational medication in combination with selective serotonin reuptake inhibitors (SSRI) in patients with obsessive-compulsive disorder. Anticipated time on study treatment is 16 weeks. Main inclusion criteria:

- Adult patients, 18 to 65 years of age
- Primary diagnosis of obsessive-compulsive disorder (OCD)
- Currently treated with an SSRI* only

* SSRIs are selective serotonin reuptake inhibitors and include the following Lexapro® (escitalopram), Celexa® (citalopram), Paxel® (paroxetine), Prozac® (fluoxetine), Luvox® (fluvoxamine), and Zoloft® (sertraline).

For Additional information, please visit:

www.skylytestudy.com

http://www.clinicaltrials.gov/ct2/show/NCT01674361?term=WN28137&rank=1

DBS for OCD: Deep Brain Stimulation for Obsessive Compulsive Disorder

Principal Investigator: Benjamin Greenberg MD, PhD
Butler Hospital
365 Blackstone Blvd.
Providence, RI 02906

Have you been diagnosed with severe OCD? If yes, and you are between the ages of 18 and 75, you may be eligible to participate in a neurosurgical treatment for OCD. Deep Brain Stimulation (DBS) for OCD is an NIMH sponsored clinical study. Nine sites throughout the US are involved in this study.

For more information, contact rmcmahon@butler.org or call (401) 455-6594.

AFFILIATE UPDATES

OCD GEORGIA

www.ocdgeorgia.org

2013 has gotten off to a good start for OCD Georgia! More than 90 people attended our first event of 2013, *OCD Unveiled!*, held on January 12 at the Dunwoody Library. Mary Plisco, PhD, presented research on factors important in the treatment of OCD in children and gave a brief introduction to OCD for those new to the disorder. Shala Nicely, the President of OCD Georgia, then shared never-before-told stories of her life with OCD and how she finally triumphed over the disorder.

We are also pleased to announce that several new volunteer officers have joined the OCD Georgia team:

- VP of Member Outreach: Christy Hall, PsyD
- VP of Therapist Outreach: Chris Noble, PhD
- VP of Marketing and PR: Kasey Brown, LMSW

The OCD Georgia team is working on developing our 2013 programming calendar, so visit us at www.ocdgeorgia.org and Facebook.com/OCDGeorgia to find out about upcoming events. If you would like to receive notifications of upcoming activities, or if you would like to volunteer, just send us an email at info@ocdgeorgia.org.

OCD JACKSONVILLE

www.ocfjax.org

Frank Morelli, LMHC from the Jacksonville affiliate conducted an *OCD in the Classroom* workshop for special educators at the North Florida School of Special Education on Friday, January 18, 2013.

OCD MASSACHUSETTS

www.ocdmassachusetts.org

OCD Massachusetts is running three monthly lecture series and support group programs throughout the state. For more information, please contact Denise Egan Stack at deganstack@gmail.com or Carla Kenney at carla@ocd-therapy.net, or visit www.ocdmassachusetts.org.

OCD MA Lecture Series* at McLean Hospital
De Marneffe Cafeteria Building, Room 132, McLean Hospital, Belmont, MA 02478

- March 5 – "Families Unite: Successful Tools for Managing OCD," by Perrie Merlin, LICSW
- April 2 – "Using ACT in the Treatment of OCD," by Nate Gruner, LICSW

*Two support groups run after each lecture

OCD MA Lecture Series* at UMass Medical Center
Lazare Auditorium (S1-607), 55 Lake Avenue North, Worcester, MA 01655

- March 14 – "Emotional Contamination," by Carol Hevia, PsyD
- April 11 – "OCD and Eating Disorders," by Jenn Alosso, PsyD

*Two support groups run after each lecture

Cape Cod Support Groups

- Falmouth – 1st Thursday of each month at 7pm. Call for more information: 508-457-0440
- Hyannis – 3rd Wednesday of each month at 6:30pm. Hyannis Youth and Community Center, 141 Bassett Lane, Hyannis, MA 02601

OCD MIDWEST

www.ocd-midwest.org

OCD-Midwest is looking forward to 2013. Upcoming events include:

1. Clinical Advisory Board meetings.
2. Consumer Advisory Board meetings.
3. Ping Pong for OCD in Chicago.
4. Launch of our website: www.ocd-midwest.org
5. Growing our Facebook Page: Facebook.com/OCDMidwestAffiliate
6. And new fundraising so that we can send a therapist to a BTTI and other local conferences.

Please contact us to assist in any of these initiatives. We are also looking for a group of people to plan a "fun" family day for families dealing with OCD. We would love to have your input. Please e-mail patrick.mcgrath@alexian.net to give us any information or ideas that you may have. Thanks.

OCD NEW JERSEY

www.ocdnj.org

Our next quarterly meeting is on Monday, March 11th, at 7:30 PM in Robert Wood Johnson Hospital (RJH) in New Brunswick, NJ. Dr. Steven Tsao of the Center for the Treatment and Study of Anxiety in Philadelphia will present *Work Smarter, Not Harder: Getting the Most out of EXRP*. This presentation will focus on maximizing the use of Exposure and Response Prevention, especially in those cases where the intervention is not working as well as it normally does.

All the quarterly meetings are free of charge and open to the general public and to professionals. For more information about upcoming meetings, please visit www.ocdnj.org.