OCDire - TOCtalk

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Quebec Obsessive Compulsive Disorder Foundation Inc.
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A Word from our President

"Hello everyone,

It is an honor for me to invite you to our 12th annual conference as the new president of the Quebec Obsessive Compulsive Disorder Foundation (QOCDF). The Foundation aims to help as many people and their families to find resources to better understand and treat this disorder. At the congress of November 15, several expert speakers will present their latest findings and will answer your questions. The organization of this day includes certain expenses plus our annual operating costs. It would be very appreciated if you could make a voluntary contribution according to your capacity ($5, $10, $20, etc.) to support the day and the mission of the organization. A designated drop box will be located at the entrance to the room to collect your donations. However, the event remains free; there is no obligation or pressure.

I also take this newsletters to introduce myself. I am 39, I am married and have two daughters aged 8 and 4 years old. I studied in administration and work in business development, specifically philanthropic management. I started having OCD at the age of 18, but I was 28 years old when a real major crisis forced me to consult a doctor and psychologist. Since that time, I worked a lot better my OCD themes of fragility through the cognitive-behavioral psychotherapy, readings, discussion groups, support of my family, meditation, spirituality and a healthy lifestyle. I managed to have a good quality of life at work and with my family, but I always have to remain vigilant. I am very happy to get involved in the QOCDF because I think we can really improve quality of life with the appropriate resources which are many. Hope to talk to you at the conference!"

Thank you very much,

Fred.

Mission of the QOCDF

The Quebec Obsessive Compulsive Disorder Foundation Inc. is a non-profit organization whose mission is to facilitate the social integration of those who suffer from obsessive compulsive disorder (OCD). Our main goals are to inform the public at large about OCD, and to offer support to those with OCD and their families. The Foundation also strives to raise the awareness of health professionals regarding this disorder so that the quality and availability of diagnosis and treatments may be improved.

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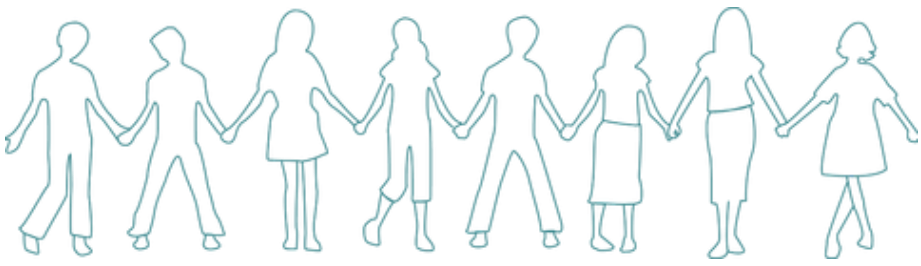

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Impulse phobia: a nightmare without awakening

By Sofia-Mina Houacine

Imagine yourself trying to hurt the dearest person to you in the world: your child, your life partner, your parents; the apple of your eye. Push them into the subway tracks, stab or even threaten them with a gun. These images are horrible, unbearable and you could almost say they are nightmares, is not it? Fortunately, we have the ability to erase the atrocities of our head to move on. By cons, people who suffering from impulse phobia can't detach from these thoughts and their imaginations are going all day designing the worst scenes of horror, even causing them insomnia in some cases.

Impulse phobia is defined as the "irrepressible desire"[1] to do harm to a loved one or oneself and fear of committing an act contrary to the "beliefs, values or feelings".[2] Although less well known than many other disorders (for example, contamination or verification), the impulse phobia falls into the category of obsessive compulsive disorder[3]. There is no typical profile of individuals who may be affected by impulse phobia. For example, women who give birth and are likely to postpartum depression may suffer from impulse phobia and feeling the urge to hurt their baby[4]. Thus, new mothers exchange their roles from a protective role to a "predator" and their child may be a victim[5]. In other cases, the individual can hurt himself. There is a suicial impulse phobia which is to have the irresistible urge to hurt. For example, there are cases in which patients were admitted to struggling to keep up when they were in the same room of a knife, when waiting for the subway or just walking on the edge of a boulevard on which passed several cars[6].

Fortunately, there are treatments to prevent and learn to control the obsessive thoughts that can convey the impulse phobia. The type of therapy recommended in the case of impulse phobia is behavioral therapy[7]. "The treatment involves exposing the person to deliberately obsessions to force him to confront the behaviors they trigger. But the therapist prevents the person from performing the ritual (response prevention)[8]." For example, if the obsession regarding the mutilation, the therapist will make the patient confronts his fear by putting a knife on his face or an object with which it could maim and accompany it to refuse to impose him these tortures[9].

If you recognize yourself in any of the situations described above, be aware that there are treatments and solutions. What you are suffering has a name and it is possible to consult a health professional to remedy your problems.

Myths and reality

People who have obsessions (aggressive thoughts), but no compulsion (i.e., check things) also have OCD.

YES. Approximately 20-30% of people with OCD do not have observable compulsions by others (i.e. washing, checking, hoarding, etc.); mostly they have intrusive thoughts. There are now treatments that are effective for both forms of OCD.

Continued on p.33

[1] Frédéric Arminot. 25 septembre 2013. «La phobie d'impulsion». In *Frédéric Arminot : comportementaliste*. En ligne. < http://fredericarminot.com/phobie-d-impulsion/ >. Consulté le 25 août 2014.
[2] Christophe André. 2004. *Psychologie de la peur : craintes, angoisses et phobies.* Éditions Odile Jacob. Paris. 361 p.
[3] *Idem.*
[4] Annick LeNestour et Blandine Guettier. 2009. *Phobies d'impulsionen post-partum : syndrome d'alarme ou processus défensif dynamique.* Enfance et psy. n.44. p.102.
[5] *Idem.*
[6] Frédéric Arminot. 25 septembre 2013. «La phobie d'impulsion». In *Frédéric Arminot : comportementaliste*. En ligne. < http://fredericarminot.com/phobie-d-impulsion/ >. Consulté le 25 août 2014.
[7] PsyMontréal (2014). *Le trouble obsessionnel compulsif.* [En ligne]. http://sante.canoe.ca/condition_info_details.asp?disease_id=277
[8] *Idem.*
[9] *Idem.*

OCD and bulimia: an exploration of comorbidity and symptom overlap

By Samantha Wilson, PhD candidate
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Definition and symptom similarities

Obsessive compulsive disorder (OCD) is characterized by recurrent obsessions (i.e., anxiety-inducing thoughts, images, or impulses that one does not want to have) and compulsions (i.e., behaviours or mental acts aimed at reducing anxiety). OCD belongs to the Obsessive Compulsive and Related Disorders category in the fifth edition of the Diagnostic and Statistical Manual (DSM 5; APA, 2013). Bulimia, on the other hand, is currently classified as an eating disorder and is characterized by the over-evaluation of body shape and weight, as well as by binge eating and compensatory behaviours. A binge episode is defined as eating a large amount of food (larger than what the average person would consume in a comparable amount of time) while experiencing a sense of loss of control. Compensatory behaviours, such as vomiting, laxative use, and fasting, are actions which are performed as a way to counteract the effects of eating and to avoid gaining weight (APA, 2013). At first glance, it would seem that OCD and bulimia are two very different mental health issues, but a burgeoning line of research suggests that these disorders have more in common than one would think. From a conceptual standpoint the intense preoccupation with one's shape and weight in bulimia is similar to the persistent obsessions in OCD (Pigott et al., 1991). Also, compensatory behaviours are similar to compulsions in that they each aim to reduce anxiety or counteract the effect of something unwanted (like an upsetting obsessive thought, or consuming a large number of calories in a binge episode; Formea & Burns, 1995). The following article will outline some other similarities between OCD and bulimia, and the importance of this type of research.

Occurrence and co-occurrence

Approximately 3% of the population is afflicted by OCD at any given time (Weissman et al., 1994). It has also been estimated that 2.6% of women will suffer from bulimia in their lifetime (Stice, Marti, & Rohde, 2013). It has been observed that a significant portion (3.6%) of people who suffer from OCD also have (or have had in the past) bulimia (Sallet et al., 2009), and vice versa, those with a primary diagnosis of bulimia have also been found to have a current or past diagnosis of OCD (13%; Speranza et al., 2001). Though high rates of co-occurrence of these disorders renders treatment more difficult and complex, this pattern provides insight into how and why OCD and bulimia develop, and may help us to discover the core processes underlying these disorders.

Perfectionism

Several different personality traits have been the focus of studies investigating OCD and bulimia as separate entities as well as those exploring the commonalities between the two disorders. One trait that has received much empirical support is perfectionism. Indeed, this trait has consistently been found to be associated with OCD (ex: OCCWG, 2003) as well as with eating disorders (ex: Bulik et al., 2003). Not only has this trait been well-documented in each disorder, but it may also help to explain some of the similarities between OCD and bulimic symptoms (Bernert et al., 2013). For example, certain compulsions and compensatory behaviours are performed in an effort to attain perfection (ex: to ensure objects are perfectly arranged; to obtain the perfect body).The comparison of perfectionism in OCD and bulimia allows for a better understanding of these disorders as they co-occur as well as adds to our conceptualization of each disorder.

Thought-fusion

Another domain which has been studied in the relationship between BN and OCD is thought-fusion. It has been found that individuals with OCD engage in a cognitive distortion known as thought-action fusion (TAF). This manifests in one of two ways: 1) believing that having a thought is as bad as carrying out the action in reality (TAF-Moral), or believing that having a thought increases the likelihood that it will happen (TAF-Probability). This is an example of a concept that has been adapted from the OCD literature and applied to eating disorders. It has been found that people with eating disorders, including those with bulimia, engage in thought-shape fusion (TSF). An example of TSF is the belief that merely thinking of a high-calorie food is morally wrong and can result in weight gain (for a review, see Shafran, Teachman, Kerry, & Rachman, 1999). The observation of similarities between OCD and bulimia allowed for the identification of a pertinent cognitive distortion in bulimia.

Conclusion

The present article focussed on a personality trait (perfectionism) and a type of cognitive distortion (thought-fusion) to illustrate the similarity between OCD and bulimia. It is important

to remember that these are just two examples, and that other similarities have been studied and remain to be studied between these two disorders. The aim of this text was not to suggest that OCD and bulimia are the same, indeed important differences also exist, but rather to illustrate the benefits of research that draws from the literature on different disorders. Not only can we discover previously unknown features of a disorder by applying concepts already established in another disorder, we can also learn about central processes that may underlie the development and maintenance of these (and possibly other) mental health problems.

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Myths and reality

OCD is little known and poorly understood by the majority of professionals (doctors, psychologists, etc.).

UNFORTUNATELY YES.

Many professionals will recognize OCD when people report known as hand washing or checking symptoms, but few will recognize the less common forms. Professionals who do not often see people with OCD often have difficulty understanding this disorder.

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The compulsion of the number 3

By Léa Bragoli Barzan, Marjorie Côté, Jérémie Dupuis et Nadine Haidar

1. Introduction: Theoretical context

Obsessive-Compulsive Disorder (OCD) is one of the most prevalent disorders, along with the major depressive disorder, substance abuse and panic disorder (APA, 1994). According to many researchers, it is a mental disorder that affects 2 to 3% of the adult population (Rasmussen & Eisen, 1989). It is a complex disorder, one that brings psychologists to question its classification. This is something mentioned in Bartz & Hollander's study (2006): Is Obsessive-Compulsive Disorder an Anxiety Disorder? According to the DSM-IV-TR (American Psychiatric Association, 2000), OCD contains obsessions or compulsions that take beyond one hour a day for the individual, and cause distress to the latter who recognizes the unrealistic nature of these. However, obsessions and compulsions are two distinct entities. The concept of obsessions refers to thoughts, images or intrusive and inappropriate impulsions which do not come from existing problems. Compulsions, on the other side, are described as being repetitive behaviors or mental acts that aim to reduce anxiety or distress. Since OCD is categorized as an anxiety disorder in the DSM-IV-TR, defining the construct of anxiety is necessary. Anxiety is a feeling of imminent danger of undetermined origin, that combines emotional, somatic, cognitive and behavioral symptoms (Santé-médecine, 2013). After an extensive research on the subject, it is important to note that there is a strong correlation between OCD patients and intolerance for uncertainty (Steketee, Frost & Cohen, 1998; Gentes & Meron Ruscio, 2011). Numerous articles and studies show that there is also a strong link between OCD and anxiety (Bartz & Hollander, 2006; Gentes & Meron Ruscio, 2011; American Psychiatric Association, 2000). Despite the presence anxiety in OCD being a certainty, the current debate rotates around the role of the latter in the disorder. A study by O'Connor and Grenier (2004) attempts to clarify the space that anxiety takes in the disorder, to find out if it holds a primary (trigger) or secondary (consequence) role, however without finding an answer. Previously classified in the "Anxiety Disorder" category of the DSM-IV-TR, obsessive-compulsive disorder does not belong to this group anymore, since the publication of the latest DSM, the DSM-V. Today, it is classified in the "Obsessive-Compulsive and Related Disorders" category, which illustrates the difficulty of classifying this disorder. According to another study, one by Bartz & Hollander (2006), obsessions cause anxiety to increase, and then diminish when undertaking a compulsion. The current case study concentrates on compulsions. More specifically, the participant has compulsions about the number 3. Considering the definition of anxiety given previously, this study aims of observing the participant's anxiety level change when she faces different stressful situations. Anxiety is measured with phenomenon like physiological changes, behaviors, and the subjective level of anxiety. As mentioned before, studies about obsessive-compulsive disorder concentrate generally on the presence and the role of anxiety in the illness. There seems to be some gaps in the literature, especially about the anxiety level change when the person is forced to obey his or her compulsion. Two questions are relevant: does not being able to obey the compulsion have an effect of anxiety? And secondly, what is the relationship between the different anxiety measures (physiological, behavioral and subjective)? Naturally, two hypotheses come up. Firstly, anxiety should increase when the participant is unable to execute her compulsions. Secondly, the three measures of anxiety should increase when the participant is unable to execute her compulsive behaviors.

2. Methodology

2.1 Participant

The participant signed a consent form, indicating the aim of the study, her role in the study, her right to retire, her right of confidentiality, as well as the advantages and inconvenient of her participation to the study. The participant is a 17-year-old young woman. She is a student in CEGEP and works part time in the fast-food industry. The first signs of the illness happened when the participant was 7 years old. She was playing soccer and, year after year, obtained always the same number on her jersey (number 3). However, that year, she had a different number and she said she was very affected by that event. She talked about it a lot with her mother, which, after some time, worried this number was taking too much space in her life. At that moment, she consulted a mental health professional and the diagnostic was given. The participant suffers of obsessive-compulsive disorder which meets the DSM-IV-TR criteria (APA, 2000). The participant's compulsion revolves around the number three and its multiple. This compulsion affects every sphere of her life (ex: turns the door handle three times, does three steps when she walks, has a routine that she does three times before going to sleep), and her compulsive behaviors increase in stressful moments (ex: exam session). It should also be mentioned that the professional who gave the diagnostic stated that taking medication in order to manage the disorder

would have negative impacts on the young girl's memory. On the basis of this information, the mother refused that should take the medication.

2.2 Measures

An increase in heart rate is strongly correlated with an increase in the anxiety level (Slaap, B. R., Nielen, M. M. A., 2004). It has therefore agreed to use a Polar watch, CE 0537 model (Polar FT40, 2002) for the physiological measure. This instrument is valid and reliable. The cardiac frequency saved on the Polar watch is strongly correlated (r = 0,93 to 1,00) with ECG (electrocardiogram) data (Alix, V., Dufort, A-M.). Using this instrument is simple and effective. It simply requires to install the transmitter that picks up frequencies on the individual, by tying the belt around the torso. Frequency is then noted at every phase and step of the experimentation. For the behavioral measure, and observation checklist was created on the basis of the participant's self-reported behaviors as well as reactions found in the literature. According to studies about this topic, anxiety is measured by electrodermal activity; an index of the activation of sweat glands (Zullino, Khazaal, Hättenschwiler & Borgeat, 2004), by the tremors, by the aggressiveness (DOUGLAS, 2013) and the irritability (EU-OSHA, 2013). The current study used two independent judges, whom did not know the participant neither the hypotheses of the study before the day of the experimentation. They both received the same information under the form of a document in which the guidelines about their task and a detailed list of behaviors to observe were stated. The judges were informed that they could not interact with each other and with the participant during the experimentation. They were free to note every observed behavior that did not appear in the pre-established list of 14 behaviors. As the observations were to be reported on the basis of the presence and the frequency of appearance of the behaviors, it was question of the nominal and scale reports. After the compilation of the results, inter-judge agreement is of .81, which is excellent according to the Landis and Koch's (1977) scale. As regards to the subjective measurement, a change has occurred. At first, it was question to elaborate an item according to a scale of the Lykert type to evaluate the participant's anxiety. However, the scientific literature preferred the Beck Anxiety Inventory in the evaluation of the subjective anxiety. It is a 21-item checklist linked to anxiety, noted on a scale from 0 (not at all) to 3 (severely – it bothered me a lot). It is then question of an instrument measured with a scale report. This type of report is renown in the field and its validity and reliability are very good. Its internal consistency is strong, with an Alpha of Cronbach of 0.92 (Beck, 1988). It seems more appropriate to use an instrument that has been validated in the literature rather than building an instrument in which the psychometric proprieties are at the risk of being false.

2.3 Procedure

This case study aims to test if the fact of restraining a compulsive behavior increases the anxiety level. The dependent variable is anxiety and the independent variable is the constraint of not doing the compulsive behavior. The procedure consists of four different phases during which the obtained results are compared to determine the anxiety fluctuation.

i) The first phase is the basis phase, in which the participant is not submitted to the evocative factor of anxiety (the constraint of not doing the compulsion). During this step, the heart rate is measured, the judges fill in the behavior checklist and for the first time, the BAI questionnaire is administered to obtain a basis measure of anxiety, in a neutral room.

ii) During the second phase (neutral), the participant is not subject to the evocative factor of anxiety. She is brought into the experimental room, where a second measure of the heart rate is taken, the judges fulfill the behavioral grid and the BAI is performed a second time.

iii) During the third phase (intermediate), the participant must perform three tests. These tests have been specifically elaborated in relation to the participant's OCD. During these tests, she is free to execute her compulsions. The evocative factor of anxiety (constraint of not performing the compulsions) is absent. During the three tests, the judges fill-in the behavioral checklist. First, seven chairs were placed in a circle and the participant must choose one. A measure of heartbeat is noted. Then, two ribbons are sticked to the floor (with a distance of two steps) and the participant must walk between these, without touching them (another measure of heartbeat is noted). At the end of these three steps, the BAI test is presented for a third time. The goal of these three tasks is to observe the expression of the participant's compulsions with the number three.

iv) The fourth phase (test) is to pass the same tests to the participant, this time by preventing her to execute its compulsions. It is in this phase that the suggestive factor of anxiety (forced to not execute compulsions) is present. Again, judges must complete the behavioral grid while the participant performed three trials. First, the participant must choose a chair from among the seven. Because she would probably sit on the chair that she believed is

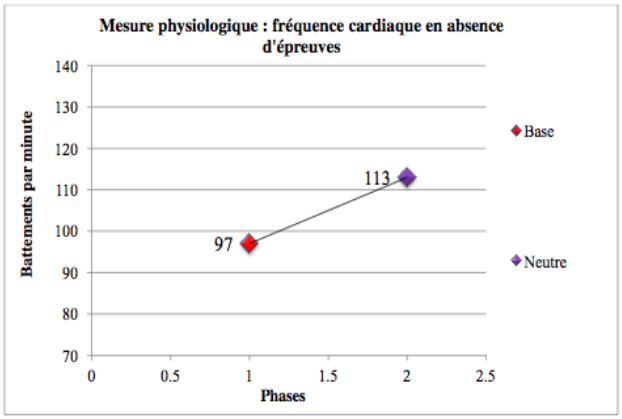
the third, researchers are trying to question his choice. She is subject to uncertainty. Questions such as: Are you sure that you chose the third chair? The chairs are round, it is impossible to choose a real beginning, maybe did you choose the fifth in reality? A measure of heart rate is recorded. Then, the participant is forced to make only two steps between the strips on the floor. The goal is to see if she is able or if she will compensate by making a third step. Another measure of the heart rate is registered at that time. Finally, at the door opening, the participant is required to rotate the grip four times. At the end of these three tests, a measure of heart rate is taken and she must complete for the last time the BAI questionnaire.

3. Results

3.1 Physiological measures

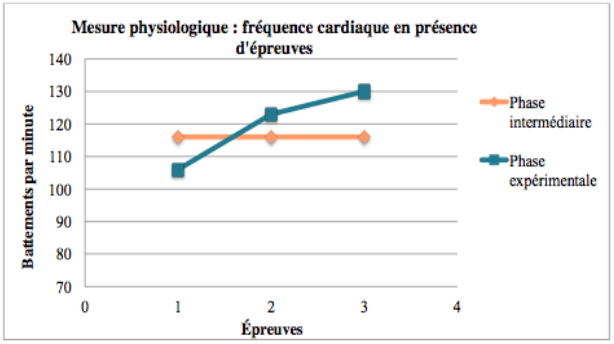
i) Base phase and neutral phase: The first graph shows the data collected during the base phase (1) and the neutral phase (2). The heart rate of the participant was 97 beats per minute at the base phase and 113 beats per minute in the neutral phase. Its frequency is high enough at the base time, it was possible to eliminate this data. However, by observing the increase of 16 beats to 60 seconds between the first and second phase, it was decided to keep the data as a tool for comparison as originally planned.

Graphique 1

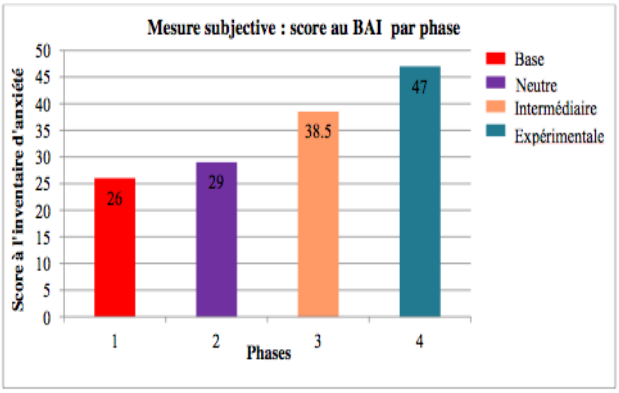


ii) Intermediate phase and experimental phase: The second graph contains the frequencies of the participant during the last two phases of the experiment based on three events in which she was subjected. First, at the intermediate phase, the heart rate is the same for all three tests, 116 beats per minute. This data is normal, because the participant was subject to anxiety tests without having to block his compulsive behaviors. During the experimental phase, it is a different. The graph shows an increase in heart rate between the second and third test, but also shows that the frequency at the first test has a decline of ten beats per minute compared with its frequency in the previous phase. The results suggest that the attempt to provoke a doubt offered the participant the opportunity to justify and explain his choice and decline his feeling of uncertainty and by the same time her heart rate.

Graphique 2



Graphique 3



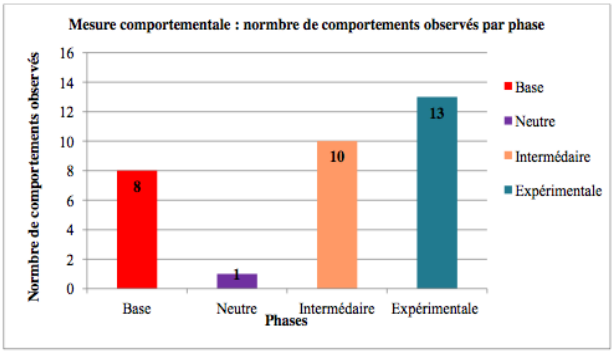
3.2 Subjective measures

The subjective measure of anxiety was measured by the Beck Anxiety Inventory. The third graph contains all the participant scores for each phase of the experiment. In the basic and neutral phases, respectively participant gets a score of 26 and 29. According to the BAI interpretation, the score indicates moderate anxiety, considerable stress that must be managed, but participant remains far from panic. It is important to note that a score of 36 on the scale, the anxiety is potentially dangerous. During the intermediate phase, the participant received a total score of 38.5, which exceeds the lower bound of significant stress. During the experimental phase, the total score reported is 47. The participant is therefore 11 points above the minimum score of significant anxiety. Over the last two phases, the participant is afraid of dying, has difficulty breathing and the amount of anxiety can potentially affect both mental and physical.

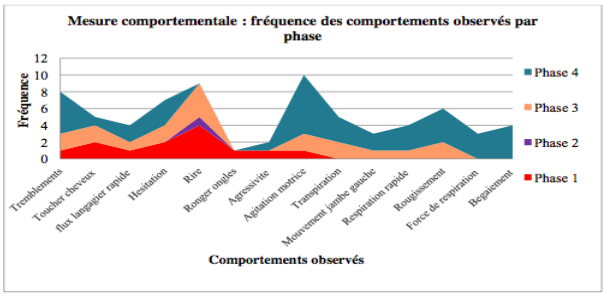
3.3 Behavior measures

The fourth graph shows the number of total rated by judges through each of the four phases of the experiment behavior. Thus, the basic phase, the judges observed behavior 8. In the neutral phase one behavior is noted. Intermediate and experimental phases, the judges rated respectively 10 and 13 behaviors in total. Regarding the frequency of occurrence of the listed on the observation grid behavior, the fifth graph is the one we must refer. Indeed, it can be seen that the behaviors that are most often manifested and through each phase are tremor, hesitation, nervous laughter, motor agitation and flushing (of the face). It also allows seeing that the neutral phase as mentioned above, one behavior has been reported or nervous laughter. This data is difficult to justify, especially because of the heart rate and anxiety score in the subjective measure at the same stage, suggesting that the participant had moderate anxiety. It seems that the anxiety reactions of the participant were manifested most often during the base phase due to the large number of individuals present she did not know. As it took nearly half an hour between the basic phase and neutral phase, the participant would have had the chance to get used to the team and thus show less anxiety behavior.

Graphique 4



Graphique 5



4. Discussion

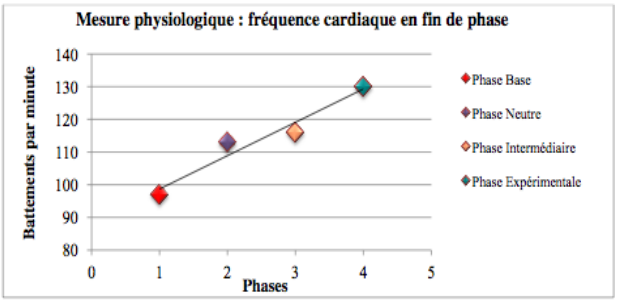
4.1 Results interpretation

Overall, our results led us to conclude that preventing our participant to perform compulsions causes a significant increase in anxiety. Between the four phases, we observed a steady increase in the heart rate of the participant. Indeed, the number of beats per minute peaked during the last phase of the experiment, when it avoided making his compulsions. We have also seen a steady increase in the number of anxiety-related behavior during the various stages of the experiment. It is the same for its BAI scores. In fact, the data of the three measures of anxiety increasingly increased through the four phases of the experiment.

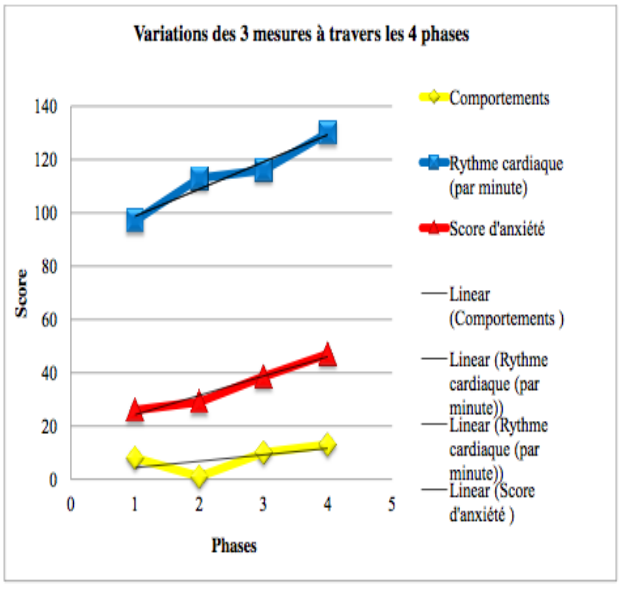
4.2 Back on hypotheses

We established two hypotheses and two were confirmed. The hypothesis assuming that anxiety increases if the participant is not forced to make his compulsions was confirmed. The assumption that the physiological, behavioral and subjective measures of anxiety increases when it is unable to make his compulsions was confirmed.

Graphique 6



Graphique 7



4.3 Back on literature

Referring to the literature, it seems merely perform an compulsion helps reduce anxiety over the obsession within the obsessive-compulsive

disorder (American Psychiatric Association, 2000; Bartz & Hollander, 2006). In the tests in which the participant was unable to perform his compulsions (experimental phase), her anxiety level increased. If anxiety increases when it can not do its compulsion, it should decrease when they can use them, thus confirming the results mentioned above. With respect to the increased anxiety of our participating in limbo (proof chairs in the experimental phase), after sitting on that it considered to be the third, the fact question his choice gave him the opportunity to justify. In this way, anxiety appears to have been modulated down. In fact, phrases like "I'm sitting on the third chair", "For me, this is the third. There are no other options "proved its intrinsic certainty to be on the third chair. This result fits into the study of Steketee, Frost & Cohen (1998) in which the correlation between intolerance of uncertainty and anxiety is discussed in OCD patients. According to the DSM-IV-TR, OCD causes great distress to the individual. We confirmed this with the Beck Anxiety Inventory (1988). Regarding the debate presented by O'Connor and Grenier (2004) on the primary or secondary role of anxiety in OCD, our study has demonstrated with certainty that anxiety plays an important role, but did not clearly distinguish the primary or secondary role of anxiety in this complex disorder.

4.4 Results implication

The results generated by our study we show that indeed compulsive behaviors a person with OCD are related to easing anxiety in it. Conversely, the failure to perform compulsive behaviors, thus preventing the free flow of compulsion, causes anxiety in the person suffering from OCD. The results of our study correspond well to the gap in the literature about the fluctuations of anxiety when the individual is unable to perform his compulsions.

4.5 Strengths and limitations of the study

Strengths of this research are mainly in the use of measuring instruments reliable and valid. Regarding the inter-rater agreement, the judges do not know, have not addressed the floor during testing and have received adequate training to be able to identify behaviors noted. The inter-rater agreement is also excellent (0.81). In addition, the participant had been diagnosed with obsessive compulsive disorder, and then we were almost certain to obtain conclusive results in performing this study. We also took care to rate a variety of behaviors depending on the presence and absence, as well as the frequency of occurrence of behavior, allowing proper use of behavioral grid and provided better fidelity of the instrument . We have also taken into account by the judges noted that were not previously on the grid behavior. The main limitation of the study is that the participant was already anxious when taking the measurement basis (first phase). This can be explained by the presence of a large number of people she did not know (four researchers and two judges), but also because it was found in an unfamiliar place. Basic measures of anxiety at that time (physiological, behavioral and subjective) probably do not reflect reality. In the intermediate and experimental phases, completing the questionnaire BAI was performed at the end of three rounds. This was done to prevent the participant does not get tired of answering the questionnaire and thus skew the results. It would have been good to have him to fill between each task (test). In addition, the participant is a friend of one of the researchers, which may have an impact in modulating anxiety upward or downward, including a systematic error in the study. Moreover, given the repetitive pattern of the experimental design, the participant could anticipate future phases and this could modulate anxiety. Finally, as is a case study, generalization of the results is difficult.

4.6 Future researches

To improve the results of this study, install a hidden camera would be relevant. This would limit the number of people present during the experiment and isolate the variable of anxiety. Install a camera would also ensure better compliance of anxiety subtle behaviors that have escaped the judges. Increase the duration of the experiment by bringing more often participating in a basal level data would most likely compare and enrich the study. However, at the end of the experiment, the participant has at least thirty minutes to return to a normal state. She counted out loud, was not focused on the conversations we had, avoiding lines sidewalk, said she had never been so stressed and we had ruined his day. That said, given the large time required to return to a time base, it would be difficult to do so within a reasonable time. In addition, repeat the experiment with more participants would better generalization results. By cons, such as OCD are specific to individuals, it is difficult to obtain generalizable results.

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Myths and reality

If I take medication to treat OCD, I will have to take them all my life.

NO, FOR MANY PEOPLE. A lot of people manage to reduce and eliminate medications, especially after receiving a behavior therapy. However, others prefer to retain the support of a medication sometimes a very small dose. For example, people who have already experienced some relapse or have a history of recurrent depression may decide to continue taking medication.

Continue on p.33

OCD – A review of the modern conceptualisations

By Jean-Sébastien Audet

Obsessive-compulsive disorder (OCD) is characterised by recurrent thoughts experienced as intrusive or unwanted and by thoughts suppression or neutralization (i.e. compulsions). It also affects between 1.1 and 1.8% of the world's population (American Psychiatric Association [APA], 2013). Interestingly, intrusions experienced by people with OCD resemble intrusions experienced by the general population in term of contents (Rachman & de Silva, 1978). This justified testing theories relevant to OCD on non-clinical population, particularly by asking people to report their intrusion and treating them as obsessions.

Cognitive theories have proposed that the underlying cause of OCD was the appraisal of intrusions (Rachman, 1997). Intrusions generating anxiety would be given significance and neutralisation techniques would therefore be used to diminish the anxiety caused by them. Intrusions would also be catastrophically misinterpreted to mean something about the person's self. Three cognitive domains contributing to the appraisal of thoughts have been identified: Responsibility/Threat Estimation, Perfectionism/Certainty and Importance/Control of Thoughts. Responsibility/Threat Estimation concerns the prevention of harm, the believed consequences of inaction and a responsibility for the occurrence of bad things. Perfectionism/Certainty refers a high standard for the completion of task, rigidity, feeling of uncertainty and the over importance of mistakes. Importance/Control of Thoughts concerns the consequence of having intrusive and/or distressing thoughts or images, believing that thoughts and actions are the same (thought-action fusion) and the need to rid oneself of intrusive thoughts (Obsessive Compulsive Cognitions Working Group [OCCWG], 2005). These would be beliefs responsible for the appraisal of thoughts as significant in OCD.

While intuitively sound, this model has a major flaw when tested empirically: these beliefs domains are not specific to OCD. Both OCD and anxious control participants obtain the same score on the Perfectionism/Control of Thoughts dimension and not more than one belief dimension is associated with any OCD subtypes (OCCWG, 2005). When controlling for anxiety, Tolin, Worhunsky and Maltby (2006) found that OCD, anxious control and non-clinical controls did not differ on any of the aforementioned belief domains. Another study found two clusters of OCD participants based on the Obsessional Beliefs Questionnaire (OBQ): one group would have higher than control group's score, while the other would score in a similar way then anxious control and student control (Taylor, Abramowitz, McKay, Calamari, Sookman, Kyrios, Wilhelm, Carmin, 2006). Interestingly, the two clusters would only be differentiated by their distress scores (anxiety and depression) and obsessions about harm, which were higher in the high scoring group. Finally, a longitudinal study found that OBQ's score would only predict OCD symptoms at baseline, but not at one, three and five year follows up (Novara, Pastore, Ghisi, Sica, Sanavio & McKay, 2011). This is problematic for the appraisal model, as OCD specific beliefs might not be specific to OCD and therefore wouldn't explain the disorder (Julien, O'Connor & Aardema, 2007). This model would be specific to the distress experienced by the people afflicted with OCD, anxiety disorder as well as for the general population. While it would be useful for people with OCD, it would not be specific to OCD and therefore it wouldn't be able to "cure" it.

These observations have led to the development of alternative models of OCD. One of the alternative model concerns inferential confusion (Aardema, & O'Connor, 2003). This model concerned itself more with the process of the thoughts than with the content of the thoughts themselves. Inferential confusion refers to confusing a "thought about a thought" with a thought. Concretely, a person would confuse the possibility of having a thought ("maybe I robed the bank") with having that thought ("I robed the bank"). Moreover, a person with inferential confusion would give less value to information coming from their environment. In our example, the person would not give importance to the fact that they didn't rob the bank or to the fact that they don't want to rob the bank. Inferential confusion is said to arise from a fear of self: a fear of what the person may be or might become (Aardema & O'Connor, 2007). In this model, a fear of the self would create inferential confusion because the person would overvalue any proof that confirms, even in a remote way, their feared self.

There is evidence that the inferential confusion model explains part of the obsessional beliefs model. Aardema, O'Connor and Emmelkamp (2006) found that controlling for inferential confusion made most obsessional beliefs' correlation non-significant with OCD symptoms. Another study found that some OBQ subscales lost their link with different OCD subtypes when taking inferential confusion into account (Wu, Aardema, & O'Connor,

2009). Also, inferential confusion is specific to OCD: OCD participants had higher inferential confusion than both clinical and non-clinical controls and it was the only measure that did not improve when OCD participants didn't respond to therapy (Aardema, Wu, Careau, O'Connor, Julien & Dennie, 2010). This confirms that the inferential confusion model is more specific to OCD than the obsessional beliefs model.

Interestingly, both models address the identity component in their theory. While Rachman (1997) proposes that people with OCD make catastrophic misinterpretation of their self based on the belief that obsessions reveal hidden aspects of their identity, particularly for repugnant obsessions, Aardema and O'Connor (2007) propose that a fear self is at the origin of the inferential confusion leading to OCD.

Proofs of such links have started to accumulate in the literature. Purdon (2001) found that intrusions appraised as meaning something about the self increased the presence of negative mood states in a student population and Rowa and Purdon (2003) found that the most upsetting intrusion of a student population contradicted their sense of self. Ferrier and Brewin (2005) found that OCD participants drew more negative inferences about themselves from having intrusions. Another study found that OCD participants had more intrusive imagery relating to unacceptable ideas of harm underlying a fear of who the person might be compared to anxious controls (Lipton, Brewin, Linke, & Halperin, 2010). Doron, Moulding, Kyrios and Nedeljkovic (2008), found that community participants most sensitive to morality reported more symptoms of OCD and Abramovitch, Doron, Sar-El and Altenburger (2013) found self-sensitivities in the morality self-domain to be the sole activator of cognitive biases related to OCD in a community sample. Finally, fear of self was found to be account for the variance explained by the OBQ in regard to unacceptable thoughts (manuscript submitted). These findings indicate that self-themes might underlie OCD, but further research should address this issue before we can consider this a fact.

Conceptualisations of OCD have come a long way in the recent years, moving from the content of beliefs to the inferential processes and self-themes. Along with the differences in conceptualisation came different therapies and methods of treatment for OCD. These methods have proven more useful and effective with each conceptualisation and it is hopeful that the self-theme approach will also yield a greater understanding and again a more effective method of treatment than the previous approaches.

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Psychobiology of trichotillomania: a developmental perspective

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Professional and scientific profile
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Trichotillomania (TTM) is a disorder of the obsessive-compulsive spectrum defined as recurrent extirpation of our own hair leading to hair loss, along with quit attempts, distress and clinically significant psychosocial dysfunction and without medical condition or another mental disorder that may better explain the symptoms (DSM-V: APA, 2013). Chronic disorder usually occurring in childhood or at the edge of puberty, most researchers try to understand the underlying mechanisms by adopting a developmental perspective. This article discusses the latest research done in this area by providing an overview of the evolution of the disorder through the ages, neurobiological findings, and finally, the animal models used to better understand the TTM.

Trichotillomania through the ages

The age of onset of trichotillomania is usually about 11-13 years, although there is another peak onset at 7-8 years (Panza, Pittenger, & Bloch, 2013). The disorder is about seven times more common in children than in adults (Bruce, Barwick, & Wright, 2005) and most adults report having started to peel in childhood or adolescence (Storch & Labouliere, 2012). Trichotillomania has a lifetime prevalence estimated at between 1% and 3% and has a strong female dominance. The bristles are mainly derived from the hair, but also the eyelashes, eyebrows, arms, legs, torso and pubic (Labouliere & Storch, 2012; Santhanam, Fairley, & Rogers, 2008). The vast majority of adult hairs are pulled out several sites, while children tend to prefer one site or their hair. These can even remove hair from their peers (Park, Rahman, Murphy, & Storch, 2012). Another difference between children and adults is the peeling style. According to experts, children have an automatic style, in other words, they peel unconsciously during sedentary activities such as reading and watching TV (Flessner, Woods, Franklin, Keuthen, Piacentini, & Cashin, 2007). Adults, for their part, use a more deliberate and conscious style that changes a negative emotional states such as anxiety and frustration (Flessner, Woods, Franklin, Keuthen, & Piacentini, 2009) aims. This change in style peeling occurs in conjunction with the cognitive and emotional development. Thus, with age, children become more aware of not only their desires, their behavior and their emotions, but also more adept at expressing them. Consequently, they would yield more value to peel less control over their desires, longer peeling and more distress over their behavior (Panza et al., 2013) term.

Trichotillomania may begin as a simple habit, like sucking the thumb (Santhanam et al., 2008). The baby is then based sucking her thumb and twirling her own hair (or those of relatives). This behavior procures more comfort when the child is upset or distressed. At preschool age, the TTM is often a well-established habit relaxing behavior, it can also represent a desire for autonomy. At school age, it can indicate stress experiences at school, at home or with peers. It can also occur in response to anxiety, a change in routine or a psychological and / or physical trauma (Roblek, Detweiler, Fearing, & Albano, 1999). Its severity varies over time, that is to say that children and adults affected, will suffer through periods of intense lifting and periods of complete abstinence lasting two weeks or more. These periods of abstinence often bring their parents to believe that the behavior is extinguished itself, delaying the treatment of disease by competent people. Unfortunately, the lack of adequate therapeutic intervention in childhood promotes chronic disease (Park et al., 2012).

Trichotillomania leads to clinically significant distress among both children and adults. Regardless of age, people who suffer spend an average of 30-60 minutes a day to peel and usually are felt ashamed, guilty, anxious and depressed. Alopecia resulting from grubbing is often accompanied by a negative body image, a constant concern about the appearance and the impression of lack of will lead to a low self-esteem (Bruce et al., 2005; Storch & Labouliere, 2012). TTM children relate social and interpersonal problems that worsen with age, either with their parents, who end up feeling angry, and incompetence, or whatever with their peers, who taunt and reject them (and Flessner al., 2009). In fact, more than half of them avoid many social situations (eg, go swimming, go to sleep at a friend's) and claim to have great difficulty concentrating, studying, or to complete their studies (Franklin et al., 2008). TTM adults live also an important interpersonal and occupational dysfunction avoiding intimacy or, being unable to perform their duties at work. Of course, the distress felt derives not only from social dysfunction, but also the inability to resist peelings. This inability leads to negatively evaluate themselves and to experience

negative affect (eg, anger, sadness, anxiety) that trigger new crises peeling. A vicious circle is created. Recognizing this, it is not surprising that trichotillomania is associated with anxiety disorders, depression, OCD and other repetitive behaviors centered on the body such as nail biting and dermatillomania (Flessner, 2012).

In addition to the psychosocial consequences, TTM poses risks to physical health. Major medical complications encountered are excoriation of the skin, skin infections, muscle fatigue and disorders of the stomach and intestines. Gastrointestinal disorders are caused by trichobezoars resulting from the ingestion of hair (Trichophagia). According to studies, the Trichophagia occurs in 10% of cases of trichotillomania and can cause death (Christenson, 1995). Hence the importance for health professionals to know and recognize the symptoms of trichotillomania and hence the importance for scientists to continue their research to better understand the development, maintenance and treatment of this disease.

Neurobiology and neuropsychology

So far, the neurobiological model suggests that trichotillomania result of a dysfunction of frontal corticostriatal circuits (Chamberlain, Blackwell, Fineberg, Robbins, & Sahakian, 2005; Flessner, Knopik, & McGeary, 2012), especially an excessive involvement of the basal ganglia that lead to behavioral recurrent perseveration and repetitive inappropriate responses (Garner, 2005; Langen, Kas, Staal, van Engeland, & Durston, 2011). The basal ganglia are involved in neural networks arranged in parallel, segregated circuits that project to specific premotor areas, primary motor areas and prefrontal cortical areas. These circuits have two paths: a direct path which increases the performance and an indirect pathway that inhibits behavior (Bradshaw, 2001; Langen et al. 2011). Corticostriatal the circuits can be divided into three macrocircuits or sensorimotreur the circuit, the circuit and the associative limbic circuit. Within these macrocircuits are microcircuits that support specific functions such as movement (sensorimotor), cognitive function (voluntary) and emotional-motivational behavior (limbic). Damage to one of these loops can lead to abnormal repetitive behavior said, as stereotyped motor behavior, impulsive behaviors and compulsive behaviors (Mason & Rushen, 2006; Langen et al. 2011).

Several studies have shown dysfunction of the basal ganglia circuits in the case of trichotillomania and classify the behavior of peeling in two categories of repetitive behavior, or impulsive behaviors and compulsive behaviors (Flessner et al., 2012). Impulsivity is the inability to use available information to reflect on the consequences of his actions, renounce an immediate reward for a larger delayed reward and inhibit motor responses (Chamberlain Odlaug, Boulougouris, Fineberg, & Grant, 2009; Singisetti, Chamberlain, & Fineberg, 2010; Flessner et al, 2012).TTM patients demonstrate impulsivity in their difficulty to resist urges to peel (although they are aware of the negative consequences of their behavior) and to resist the immediate relief provided by peeling (although they benefit a deferred greater welfare if they resisted). In addition to the impulsive dimension, trichotillomania has a compulsive dimension. The compulsion is a repetitive behavior whose purpose is to avoid pain or to reduce negative affect, it is expressed in people TTM in the fact that many of them peel to reduce negative emotions. However, unlike patients suffering from obsessive-compulsive disorder, compulsions tear are not preceded by obsessions (Lapidus, Stern, Berlin, & Goodman, 2014).

Animal models, environment and genetics

Trichotillomania, dermatillomanie, nail biting are often grouped under the name disorders grooming (grooming disorders) because they have phenomenological similarities with their counterpart animals (Singisetti et al., 2010). Indeed, the behavior of the barber, a type of grooming behavior, is a common phenotype in a variety of animal species in captivity with the mouse, six non-human primates and birds (Dufour & Garner, 2010). TTM as humans, the behavior of the barber is associated with a significant hair loss, occurs more frequently in females, usually starts at reproductive maturity, increases in frequency with age and is sometimes accompanied by Trichophagia. In addition, barbers animals are similar to those of TTM patients neuropsychological features, including possible dysfunction of corticostriatal circuits in the basal ganglia (Chamberlain et al., 2005; Dufour & Garner, 2010).

The fact that the behavior of the barber appears only in captive animals suggests that the conditions of captive life is an important environmental stress that interferes with brain development and behavior (Dufour & Garner, 2010). The captive animal is disturbed in its adaptation vis-à-vis its habitat that innate behaviors adapted in nature are useless in captivity, leading to frustration and stress in animals process. Of these disturbances emerge deficits in brain function, which then would trigger the development of dysfunctional behaviors (Garner, 2005). The hypothesis of social stress as a trigger behavior

barber is supported by studies showing that an enriched environment decreases the severity of the behavior of barber (DeLuca, 1997; Dufour & Garner, 2010) while an increase in metal cage incidence (Garner, Dufour, Gregg, Weisker, and Mench, 2004). In humans, remember that trichotillomania is often associated with stressors such as early psychosocial traumas and negative emotional states.

Certainly, although important, the environment can not alone explain the appearance of behavior barber, hence the need to study the role of genetics and its complex interaction with the environment. In animals, alterations in the behavior of the barber were induced in the knockout mouse Hoxb8 gene and gene knockout mice SAPAP3 (Greer and Capecchi, 2002; Flessner et al, 2012;. Dufour & Garner, 2010). In humans, researchers have found multiple variations of SAPAP3 gene in TTM patients (Flessner et al., 2012) and others suggest the involvement of variations in the 5HT2A receptor gene serotonin (Hemmings et al. 2006 Singisetti et al, 2010).. Also, although few, studies exploring heritability and comorbidity of TTM found high levels of anxiety, depression, OCD and TTM in the first-degree relatives (Bienvenu et al. 2000). In addition, a study with twins showed that monozygotic twins have a higher trichotillomania that dizygotic twins concordance (Novak, Keuthen, Stewart, & Pauls, 2009; Stein & Lochner, 2012). Thus, although the heritability seems essentially modest, these results are encouraging scientists to pursue this path.

Conclusion

Trichotillomania differs in its development, its expression and function. In infants, it can start as a simple habit while in school-age children, it's often a response to the stress of school and peers. TTM usually occurs during adolescence as a reaction to distress face many psychosocial and hormonal changes; and finally, in adults, it is often used to change a negative affective state. Peeling is usually done alone secretly, and alopecia is often hidden by various aesthetic means (eg wearing a hat, scarf, makeup, wig), the TTM often pass unnoticed. Therefore, it has the opportunity to firmly establish and become chronic. One promising research into the etiology and treatment of trichotillomania is the behavior of the barber in animals considered as a valid animal model. Of course, once the mechanisms by which altered genotypes influence the phenotype of the barber will be elucidated, there is no evidence that they apply to complex human behaviors, but hope is not in vain. Certainly, the fact that further research to better understand the evolution of trichotillomania, its characteristics through the ages and its underlying biological mechanisms, will certainly improve the quality of treatment and quality of life of people suffering.

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Obsessive-compulsive disorder in children and adolescents: family, social and school impact and interventions.

By Annie Surprenant
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Laboratoire d'étude des troubles de l'ordre de la psychopathologie en enfance (LETOPE)

What is obsessive compulsive disorder?

According to the DSM-5 (American Psychiatric Association, 2013), obsessive-compulsive disorder (OCD) is characterized by obsessions and / or compulsions. Obsessions are defined by persistent, recurrent and intrusive images or thoughts. According to Berthiaume, Turgeon and O'Connor (2004), individuals with OCD invest excessive attention to these obsessions and it's create anxiety. People generally recognize the irrational nature of these obsessions. Thoughts and images of people with OCD are never completely false, but they are exaggerated and anxiety characterize this psychological disorder (Berthiaume, Turgeon and O'Connor, 2004). According to the DSM-5 (APA, 2013), compulsions are defined as repetitive behaviors or mental acts that the person feels compelled to perform in order to reduce anxiety or distress caused by the obsessions. Obsessive-compulsive symptoms must cause significant distress and significantly interfere with the functioning of the person. In addition, the obsessions and compulsions must have a duration of more than one hour per day.

What distinguishes OCD in children?

Obsessive-compulsive disorder in children is diagnosed using the same criteria as those used for adults. The DSM-5 does not specify a precise and specific criteria for children. In contrast to adults, children sometimes have difficulty recognizing the incredible and irrational nature of obsessions (Berthiaume, Turgeon and O'Connor, 2004). Some children may have difficulty identifying the reasons why they perform their compulsions (Berthiaume, Turgeon and O'Connor, 2004). Usually, the specific content of obsessions is directly related to compulsions done to reduce anxiety (Dansereau and Bouchard, 2004). However, sometimes, the relationship seems inexplicable to others. Some obsessive themes are common in children, such as thoughts of an upcoming disaster, fear of harm self or others, contamination, sexuality and a need for symmetry or exactness (Berthiaume Turgeon and O'Connor, 2004; Laverdure, 2011 Dansereau & Bouchard, 2004). Frequent compulsions concern verification, washing and cleaning, counting, ordering, arranging and touch excessively things (Berthiaume, Turgeon and O'Connor, 2004; Dansereau and Bouchard, 2004).

Clinical profile of OCD

OCD generally would appear around the age of 10 years (Berthiaume, Turgeon and O'Connor, 2004). The prevalence of OCD would be between 1.6 % and 2.5 % in adults and between 0.25 % and 3.6 % in children (Berthiaume, Turgeon and O'Connor, 2004; Laverdure, 2011). In adults, there seems to be no gender difference in prevalence. In children and adolescents, the data are more controversial. Some authors reported a slightly higher prevalence among boys (March & Mulle, 1998). Other authors report that boys are more likely to develop OCD before puberty, while among girls OCD would appear rather in adolescence (March & Mulle, 1998). Boys would have more obsessions and less compulsions (Berthiaume, Turgeon and O'Connor, 2004). On the other hand, girls have less checking rituals and compulsions of cleaning and washing and a higher levels of anxiety (Berthiaume, Turgeon and O'Connor, 2004). The variation in the prevalence of OCD can be explained by the difficulties related to the assessment of OCD firstly because the instruments used and secondly the concurrent disorders. It is possible that OCD in children and adolescents may be under-diagnosed because they often prefer to remain silent for fear of being judged (Berthiaume, Turgeon and O'Connor, 2004).

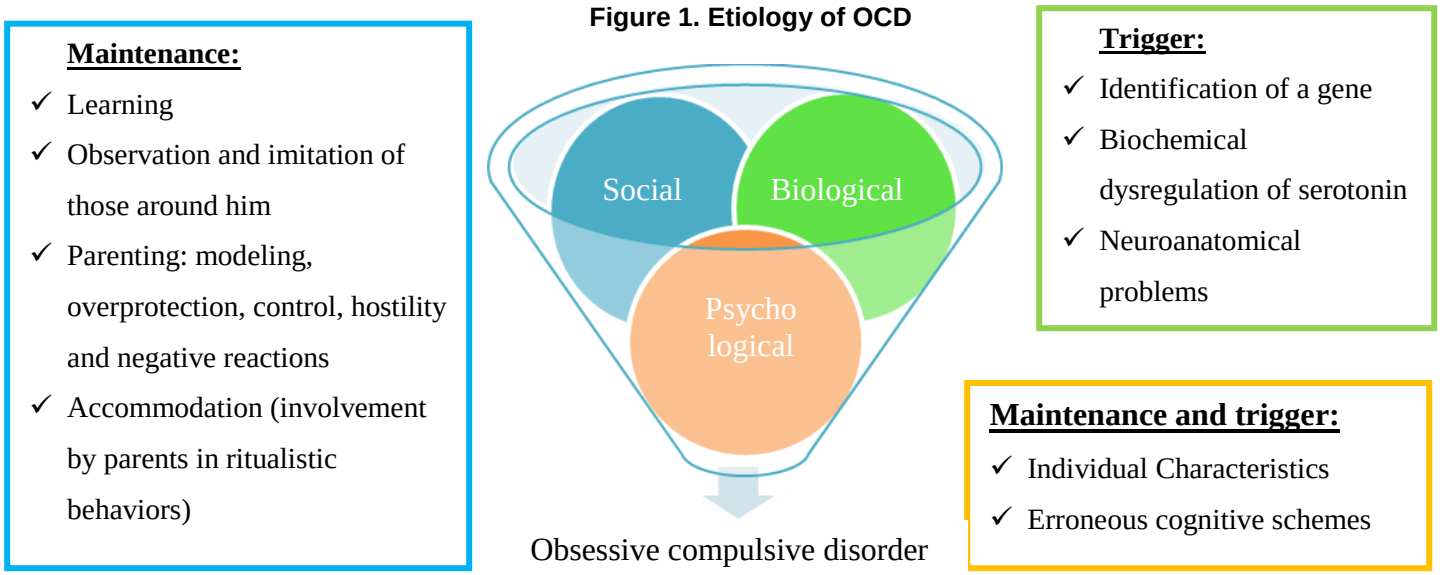
As reported by Berthiaume, Turgeon and O'Connor (2004), Laverdure (2011), Dansereau & Bouchard (2004) and March & Mulle (1998), concurrent disorders most often identified with OCD in children are depression, anxiety disorders such as generalized anxiety disorder, specific phobia and separation anxiety and externalizing disorders such as oppositional defiant disorder and deficit of attention with hyperactivity disorder. Also, other disorders are often confused with OCD some of tics, trichotillomania, Gilles de la Tourette syndrome, autism spectrum disorder and eating disorders.

Etiology

The etiology of OCD as adults than in children remains partially unknown and much research is needed to investigate the possible causes. The main theories could be grouped into a triadic bio-psycho-social model. Indeed, several authors suggest that an interaction between biological, psychological (individual) and social could explain the development and maintenance of

OCD (March & Mulle, 1998). It would be the interaction between biological and environmental factors that influence the initiation and maintenance of OCD, but each of the factors would not have the same impact. Also, a single factor is not sufficient to trigger OCD. For example, the dynamic of family can't be the only one cause of the development of OCD. **Figure 1** shows the possible etiological causes mentioned in the scientific literature (Berthiaume, Turgeon and O'Connor, 2004; March & Mulle, 1998):

Figure 1. Etiology of OCD



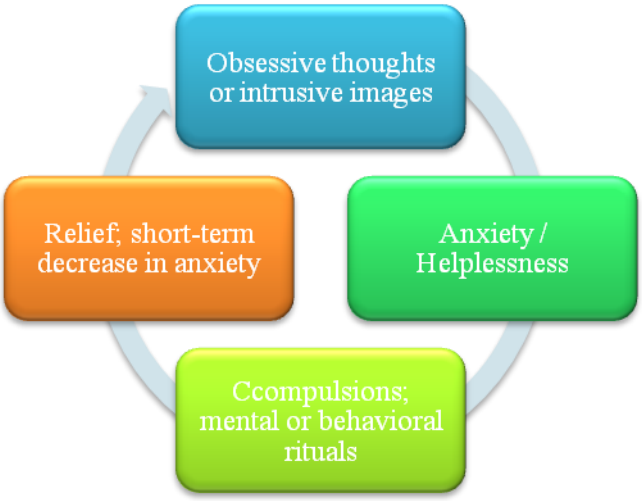


Figure 2. OCD cycle

Family, social and educational impact

OCD in children interferes with the routine, the family, social activities, interpersonal relationships and the school (Laverdure, 2011). Compulsions are sometimes so present that the child fails to perform in daily activities, sleep a sufficient number of hours and play sports. Therefore, these children become irritable, tired and isolated. **Figure 2** shows the cycle of obsessive-compulsive disorder. Obsessive thinking appears in children (i.e., my hands are contaminated or maybe I made a mistake). This idea increases the anxiety and distress of the child to prevent him from concentrating or continue the normal course of these day. Therefore, the child do a compulsion (i.e., washing hands or recheck his duty), which aims to relieve and reduce anxiety temporarily. Since the compulsion tends to relieve and reduce anxiety, it involves a process of negative reinforcement. Indeed, anxiety or distress is an unpleasant stimulus, the withdrawal of anxiety by the manifestation of a compulsion increases the likelihood of a recurrence of compulsion the next time the child will feel the induced anxiety by

obsessive thinking. The cycle is reinforced see **Figure 3**.

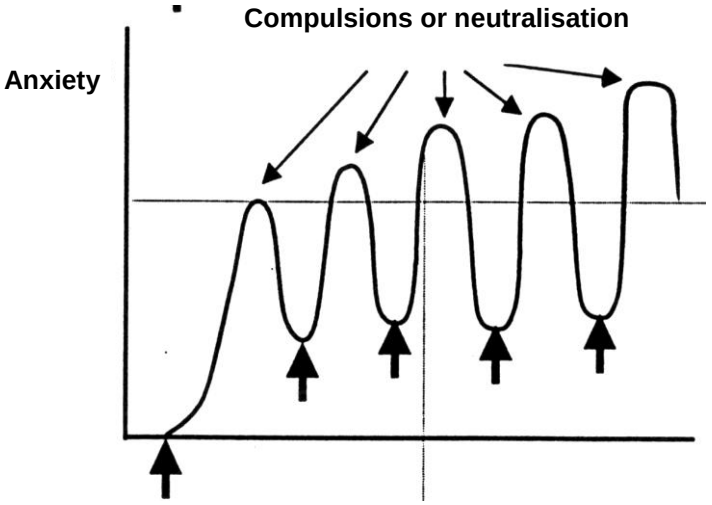


Figure 3. Negative reinforcement of OCD

Certain behaviors in children and adolescents aim to neutralize the obsessions and compulsions. Such behavior can take many forms such as reinsurance to close (i.e., ask the entourage to check or ask for them to be constantly reassure) and avoidance (Berthiaume, Turgeon and O'Connor, 2004; Laverdure, 2011). Avoidance can be considered a form of negative reinforcement. Avoiding going into places where increasing obsessions, anxiety or distress is reduced which has the effect of removing an unpleasant stimulus. So there is a building to avoid certain situations. Some parents are directly involved in the ritual of the child, it is the accommodation (Berthiaume, Turgeon and O'Connor, 2014; Laverdure, 2011). Some parents will do the demands of their child to avoid a crisis or anxiety. For example, if the child complains to not want to eat in only one dishes, his parents will always make sure to have in hand the favorite dishes regardless of where they are going to eat.

Some children spend so much time doing their obsessions and compulsions that they spend none time having fun, create friendships and play with other students (Dansereau & Bouchard, 2004). The avoidance of social contact with peers is often observed. OCD in school can lead to physical and mental exhaustion in children because children try to hide their behavior in order to mingle with their friends which can cause an increase in obsessive-compulsive behaviors at home (Laverdure, 2011 Dansereau & Bouchard, 2004). In fact, children are more anxious, trying the best they can to control their actions, focus on what they think, say and do and constantly afraid that another student noticed some " weird behaviors".

The teacher may have some evidence of the occurrence of OCD in detecting some unusual behavior in children (Laverdure, 2011). For example, a child with OCD can be late for school because of time spent in rituals at the start of the house (Laverdure, 2011). He can often experience difficulties and even failure in school because he is slower in the tasks imposed and is unable to complete the exercises (Dansereau & Bouchard, 2004). The student may have difficulty of attention because of his obsessions. In addition, students can read and reread their writing constantly, delete repeated words and phrases and too carefully fill any questionnaire and be unable to complete the exercise in time (Dansereau & Bouchard, 2004). Also, the child may wonder and ask lots of questions before performing several actions or gestures and ask the teacher to repeat instructions or explanations (Dansereau & Bouchard, 2004). According to Dansereau and Bouchard (2004), the student can use a piece of clothing, toilet paper or tissue to touch a doorknob, can have red hands and injured due to excessive washing, can check a multitude of things repetitively and excessively, arrange all objects on their desks so that there is a perfect symmetry and avoid contact with glue, clay, paint, chalk or scissors for fear of dirty or injury their self.

Avenues of intervention

<u>For parents:</u>

- ✓ Limit accommodation, that is not to get involved in the ritual of the child. Thus, the behavior is not reinforced and maintained (Berthiaume, Turgeon and O'Connor, 2014; Laverdure, 2011). Such behavior can take many forms such as distraction (i.e., singing, playing and talking with friends), requests for reinsurance to close (ask the entourage to check or ask them to be constantly reassure) and avoidance of anxious situations (avoid going to places where obsessions increase) (Berthiaume, Turgeon and O'Connor, 2004; Laverdure, 2011).
- ✓ Get involved in the treatment of her child because it promotes adhesion and response to it (Berthiaume, Turgeon and O'Connor, 2014). For example, by going to meetings, making sure that the homework given by the therapist were completed, encouraging the child when making progress, etc.
- ✓ Decrease negative reactions and interactions, such as a high level of hostility and criticism to promote the effectiveness of a treatment (Berthiaume, Turgeon and O'Connor, 2014; Laverdure, 2011). For example, make sure you

have a quiet and supporting home environment (Laverdure, 2011), suitable to change and where the efforts and successes are identified and strengthened, etc.

- ✓ Try to control their own thoughts and behaviors, because some parents have obsessive-compulsive symptoms without having a diagnosis of OCD (Berthiaume, Turgeon and O'Connor, 2014).
- ✓ Tell the teacher that the child suffers from OCD may be appropriate in some cases, since it can contribute to the proper functioning of the child in the classroom (Dansereau & Bouchard, 2004). However, we must consider whether there is a significant teacher and if the child agrees and what kind of things he agreed to disclose or not. In high school, the situation must be evaluated on the organization and functioning of the student.

For teachers:

The school environment may increase the effects of an intervention for students with OCD. Indeed, by changing its behavior at home and at school, the child can more easily implement the strategies that are taught (Dansereau & Bouchard, 2004).

- ✓ Decrease homework and exercises to do at home as a student with OCD often feels obliged to deliver a perfect job and he constantly gets into them. Using a computer can help students.
- ✓ Submit teamwork to facilitate integration, promote exchanges with other students and reduce competitiveness (Dansereau & Bouchard, 2004).
- ✓ Change activity if he is taken in a ritual to redirect his attention.
- ✓ Allow a little more time for the student or opt for other forms of assessment. Some tests may disadvantage a student with OCD since they can sometimes have a greater slow performance and are often anxious. Oral exams or recorded answer using a tape recorder can be an alternative (Dansereau & Bouchard, 2004).
- ✓ Decrease the number of assessments and numbers. The time can have a perverse effect because some children with OCD will take the time to do all their compulsions.
- ✓ Supervise the number or duration of rituals with a timer.
- ✓ Establish small group relaxation sessions (Dansereau & Bouchard, 2004) and breaths to reduce the overall level of anxiety.
- ✓ Identify the obsessions and compulsions of the student. For example, paying attention to the time required to perform a task, the time spent in the bathroom and daily delays (Laverdure, 2011 Dansereau & Bouchard, 2004).
- ✓ Establish a system of communication between the student and the teacher. For example, if the child needs help, he can show a red card. If he wants to try to control his own compulsive behavior, he shows a green card. The goal is to encourage students to control his own obsessions and compulsions (Dansereau & Bouchard, 2004).
- ✓ Encourage communication with parents by the agenda to note the key behaviors observed during a day and evaluate progress.
- ✓ Avoid unfair reprimands against compulsions and educate other students to the reality experienced by a child who has OCD (Laverdure, 2011). Whereas the punishments increase the anxiety level of the student, teachers must avoid using them. Thus, the teacher should focus on the strength of appropriate behaviors.

In conclusion, it is important that parents and teachers know identify the symptoms of OCD. Teachers spend several hours a day with the students and can have an impact in the assessment and intervention for students with OCD. If a teacher feels that one of his students has OCD, it is best to inform the school psychologist that he can conducts a thorough assessment of the situation. Each intervention should be tailored to the child or young person to whom it is addressed. Interventions can be creative and aim to reduce compulsions without reinforcing the cycle of TOC. It must still be noted that the treatment of choice for OCD in children and adolescents remain psychotherapy, medication or a combination of both. Although family and teachers can help the treatment, they are not the only actors in the development, maintenance and treatment of OCD. Obsessive-compulsive disorder is a very complex psychological disorder and much research remains to be conducted.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders, (5th ed.). Washington, DC: American Psychiatric Association.

Berthiaume, C., Turgeon, L. et O'Connor. (2004) L'évaluation et le traitement psychologique du trouble obsessionnel-compulsif chez les enfants et les adolescents : Découvertes récentes. *Journal de Thérapie Comportementale et Cognitive, 14, 1, 35-46.*

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March, J.S. & Mulle, K. (1998). OCD in Children and Adolescents: A Cognitive-Behavioral Treatment Manual, New York; The Guilford Press.

OCD and the media

« La vie en paradoxes »: vivre avec le trouble obsessionnel compulsif

DVD featuring:

Dr O'Connor leading a support groups for the OCD; ten stages of the therapy based on the inferences. A scenario is made by the psychologist Natalia Koszegi. Finally, Dominique Charron makes a short testimony of her experience with the therapy based on the inferences. A useful tool for the psychologists, the students and for the people who have OCD and want to understand this type of therapy.

Price: 5$
Link to buy the DVD:
http://www.iusmm.ca/cetoct/vente-dvd-cetoc.html

Hudon cause pour la cause

Short report and testimony of a young hockey player who has OCD for the Bell let's talk campaign.

To see the report: http://www.rds.ca/hockey/lhjmq/hudon-cause-pour-la-cause-1.837028
Il y a deux partie au reportage, les deux sont disponibles via le lien ci-haut.

Se laver les mains 100 fois par jour, être obsédé par le ménage, ça peut être un trouble obsessionnel compulsif. Souffrez-vous d'un TOC?

Isabelle Maréchal

To listen the radio show:
http://www.985fm.ca/audioplayer.php?mp3=161004

Souffrez-vous d'un trouble obsessionnel-compulsif... un toc?

Marie Plourde

To listen the radio show:
http://www.985fm.ca/audioplayer.php?mp3=141491

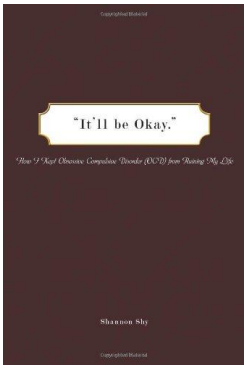
Épisode c'est ma vie!

Television program at canal vie; Proprio en otage

Episode which illustrates a case of hoarding where intervenes the psychologist Natalia Koszegi.

http://proprioenotage.canalvie.com/episode/c-est-ma-vie

Reading on OCD



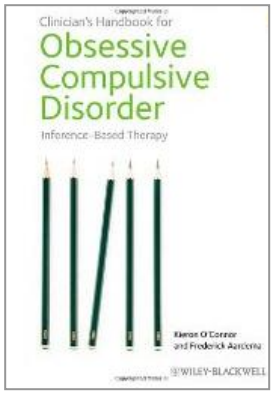
"It'll be Okay": How I Kept Obsessive-Compulsive Disorder (OCD) from Ruining My Life
By Shanon Shy

Price: $10
Link to buy the book:
http://www.amazon.com/Itll-Okay-Obsessive-Compulsive-Disorder-Ruining/dp/1438957319

Entre monts et merveilles
By Kieron O'Connor, Natalia Koszegi and Marie-Ève St-Pierre-Delorme

Price: $25
Link to buy the book:
http://multim.com/titre/?ID=365

To our knowledge, there is no guide in French about this problem becoming more frequent in our consumer society. That's why it seemed essential to us to produce one. This book is made as a practical clinical guide, who allows getting ourselves out step by step of this disorder. Several forms of treatment can be applied: the auto treatment, the individual treatment with a psychologist, as well as the group treatment.

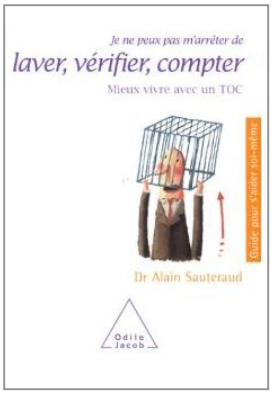


Clinician's Handbook for Obsessive Compulsive Disorder: Inference-Based Therapy
By Kieron O'Connor and Frédérik Aardema

Price: $45
Link to buy the book:
http://www.amazon.ca/Clinicians-Handbook-Obsessive-Compulsive-Disorder/dp/0470684100

Je ne peux pas m'arrêter de laver, vérifier, compter. Mieux vivre avec un TOC
By Alain Sauteraud

This book allows you to treat actively your problems; you will find all the useful information to understand the obsessions and compulsions. You will discover how to react with effective methods; you will know finally how to face your problem or the one of your relatives day by day. The first practical guide on OCD updated to accompany yourself in your initiative of change.



The Quebec Obsessive Compulsive Disorder Foundation's professional resources list
Compiled by Kieron O'Connor, Cathy Léveillé, Édith St-Jean-Trudel and Annie Taillon

The information appearing on this list was retained via surveys. That is, it was selected by our team solely on the basis of it's relevance, and no particular screening procedure was performed. People interested in seeking professional services from any of the specialists appearing on this list need to contact these professionals directly or seek further assistance from the *Ordre des Psychologues du Québec* - (514) 738-1881; 1-800-363-2644. The Quebec Obsessive Compulsive Disorder Foundation as well as the scientific advisors and their research team do not, under any circumstances, take any responsibility for any given services. Some modifications were made in October 2014 by Annie Surprenant.

Eastern Townships

Forest, Gilles

Address: 71 Rue Metcalfe Sherbrooke
Telephone: 819 564-3232
Email: g.forestpsy@sympatico.ca
Profession: Clinical psychologist
Theoretical approaches: Cognitive behavioral therapy; psychodynamic/analytic psychology; neuropsychology
Specializations: OCD management, assessment, treatment, advice/support, education
Clientele: Adults, eldery
Languages: French, English

Lanaudière

Cormier, Francine

Address: 557 Rue Ponsard Repentigny
Telephone: 450 654-6250 or 450 603-0896
Email: fcormier.psy@videotron.ca
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: Assessment, treatment, advice/support
Other disorders: Tics, habit disorders, hoarding, hypochondria
Clientele: Children, adolescents, adults, eldery
Languages: French, English

La Prairie

Goulet, Geneviève

Address: 114 Rue Saint Georges La Prairie
Telephone: 514 441-3802
Email: genevieve.goulet.psy@gmail.com
Profession: Clinical psychologist
Theoretical approaches: Cognitive behavior therapy
Specializations: OCD management, assessment, treatment
Other disorders: OCD spectrum disorders, eating disorders, anxiety disorders (except post-traumatic stress disorder), depression, burnout, adjustment and relational difficulties
Clientele: Adults, adolescents (15 years old and over)
Language: French

Laurentides

Leblanc, Vicky

Address: 450 Boul Mgr-Dubois Suite 203 Saint-Jérôme
Telephone: 450 438-3838
Email: vickyleblanc06@hotmail.com
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: OCD management, evaluation, treatment, advice/support, education
Clientele: Children, adolescents, adults, elderly
Langue: French

Laval

Bouthillier, Donald

Address: 1435 Boul Saint-Martin O Suite 603 Laval
Telephone: 514 774-7304
Email: drbou@videotron.ca
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: OCD management, assessment, treatment, advice/support, education
Other disorder: Hypochondria
Clientele: Adolescents, adults
Language: French

Grenier, Sébastien

Address: Clinique d'Anxiété de Laval, 255 Boul de la Concorde O Suite 206 Laval
Telephone: 450 629-5992
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: Assessment, treatment, education, research
Other disorders: Hoarding
Clientele: Adolescents, adults, elderly
Language: French

Taillon, Annie

Address: Clinique multidisciplinaire de Laval, 500 Boul Saint-Martin O Suite 490 Laval
Telephone: 514 727-5395
Email: taillon.annie@gmail.com
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: OCD management, assessment, treatment, education, research
Other disorders: Obsessive-compulsive spectrum, anxiety and mood disorders
Clientele: Adults, teens (16 years old and over)
Languages: French, English

Mauricie

Brochu, David

Address: 1340 Rue de Paris Trois-Rivières
Telephone: 819 697-3864
Email: www.dbpsy.com

Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: OCD management, assessment, treatment
Other disorders: Hoarding, hypochondria, generalized anxiety disorder
Clientele: Adults
Language: French

Langlois, Frédéric

Address: Département de psychologie, Université du Québec à Trois-Rivières, CP 500, Trois-Rivières
Telephone: 819 376-5011 extension 3557
Email: frederic.langlois@uqtr.ca
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: OCD management, assessment, treatment
Other disorders: Hoarding, hypochondria, generalized anxiety disorder
Clientele: Adults
Language: French

Montérégie

Bissonnette, Nathalie

Address: Centre de Psych. Bissonnette & associés, 195 Rue Saint-Charles O Suite 202, Longueuil
Telephone: 450 679-9989
Email: psychologiebissonnette@qc.aira.com
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specialization: Treatment
Other disorders: Generalized anxiety disorder, addictions, post-traumatic stress disorder
Clientele: Adolescents, adults
Languages: French, English

Guay, Isabelle

Address: 458 Av St Charles Suite 204 Vaudreuil-Dorion
Telephone: 450 510-2807
Email: i.guay@videotron.ca
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: OCD management, assessment, treatment, advice/support, education
Other disorders: Hoarding, body dysmorphic disorder, habit disorders, hypochondria
Clientele: Adults
Language: French

Marchand, Lyne

Address: 458 Av St Charles Suite 204 Vaudreuil-Dorion
Telephone: 514 758-7758
Email: lyne.marchand.hsc@ssss.gouv.qc.ca
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: Psychotherapy and diagnostic
Other disorders: Depression, chronic pain, fibromyalgia, anxiety disorders, phobias, panic disorders, etc.
Clientele: Adolescents, adults, elderly
Language: French

Montréal

Aardema, Frederick

Address: 7331 Rue Hochelaga Montréal
Telephone: 514 251-4015 extension 3534
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: OCD management, assessment, treatment
Other disorders: OCD spectrum disorders, anxiety, depression, panic disorder, phobias, tics
Clientele: Adults
Language: English

Adler, Perry S. J.

Address: 4115 Rue Sherbrooke O Suite 410 Westmount
Telephone: 514 738-3732 extension 22
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: OCD management, assessment, treatment, advice/support, education
Other disorders: Hoarding, habit disorders, hypochondria
Clientele: Adolescents, adults, elderly
Language: English, French

Bernard, Marc-André

Address: 419 Boul Rosemont Suite 204 Montréal
Telephone: 514 758-5008
Email: ma.bernard.psy@gmail.com
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: OCD management, assessment, treatment, advice/support, education
Other disorders: OCD spectrum disorders, anxiety disorders, obsessive-compulsive personality disorder
Clientele: Adults, elderly
Languages: French, English

Bleau, Pierre

Address: 1650 Av Cedar Montréal
Telephone: 514 934-1934 extension 31794
Email: pierre.bleau@mcgill.ca
Profession: Psychiatrist
Theoretical approaches: Cognitive behavioral therapy; psychopharmacology
Specializations: Assessment, treatment
Clientele: Adults, elderly
Language: English, French

Bolduc, Daniel

Address: Centre de Psychologie Béhaviorale, 1575 Boul Henri-Bourassa O Suite 440 Montréal
Telephone: 514 336-5562
Email: cpb210@bell.com
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: OCD management, assessment, treatment, advice/support, education
Other disorder: Hypochondria
Clientele: Adults
Languages: French, English

Brisson, Linda

Address: Centre de Psychologie Béhaviorale, 1575 Boul Henri-Bourassa O Suite 440 Montréal
Telephone: 514 336-5562
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: Assessment treatment, advice/support
Other disorders: Tics, hypochondria
Clientele: Adults
Language: French

Centre de Psychologie Béhaviorale

Address: 1575 Boul Henri-Bourassa O Montréal
Telephone: 514 336-5562
Website: www.cpbmontreal.ca
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: Assessment treatment, advice/support
Other disorders: Tics, hoarding, hypochondria
Clientele: Adolescents, adults
Language: French

Centre d'études sur les troubles obsessionnels-compulsifs et les tics du Centre de IUSMM

Address: 7331 Rue Hochelaga Montréal
Telephone: 514 251-4015 extension 3585
Email: kbergeron.crfs@ssss.gouv.qc.ca
Website: ww.tictactoc.org
Theoretical approach: Cognitive behavioral therapy
Specialization: Research project on the treatment of OCD
Other disorders: Body dysmorphic disorder, Tics, Gille de la Tourette syndrome, hoarding
Clientele: Adults, adolescents
Languages: French, English

Clinique du Trouble Obsessionnel-Compulsif du Centre Universitaire de Santé McGill (CUSM)

Address: 1025 Av des Pins O Montréal
Telephone: 514 934-1934 extension 34290
Email: Debbie.Sookman@mcgill.ca
Theoretical approach: Cognitive behavioral therapy
Specializations: Research project on the treatment of OCD
Other disorders: OCD spectrum disorders
Clientele: Children, adolescents, adults
Language: English, French

Duchesne, Chantal

Address: 1150 Boul Saint-Joseph Est Suite 304 Montréal
Telephone: 514 382-9267
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specialization: Treatment
Other disorders: Tics, hypochondria, OCDS
Clientele: Adults
Language: French

Greenstone, Harriet

Address: 3675 Boul des Sources Suite 203 Dollard-des-Ormeaux
Telephone: 514 683-8791
Email: info@centremdc.com
Profession: Clinical psychologist
Theoretical approaches: Cognitive behavioral therapy; psychopharmacology
Specializations: OCD management, assessment, treatment, advice/support, education
Other disorders: Tics, habit disorders, hoarding, hypochondria
Clientele: Children, adolescents, adults, elderly
Language: English, French

Leblanc, François

Address: 1150 Boul Saint-Joseph Est Suite 304 Montréal
Telephone: 514 382-9267
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: Anxiety disorders in general
Other disorder: Hypochondria
Clientele: Adolescents, adults, elderly
Languages: French, English

Lévesque, Mireille

Address: 4549 Rue St-Hubert Montréal
Telephone: 514 202-2447
Email: mirelevesque@hotmail.com
Profession: Clinical psychologist
Theoretical approaches: Cognitive behavioral therapy; existential-humanist psychology
Specializations: OCD management, assessment, treatment, advice/support, research
Other disorders: Tics, habit disorders, hoarding, hypochondria, gambling, body dysmorphic disorder
Clientele: Adolescents, adults, elderly
Language: French

Marquis, Rachel

Address: Centre Médical St-Urbain, 3875 Rue Saint-Urbain Suite 403 Montréal
Telephone: 514 288-0408
Email: r.marquis@bellnet.ca
Profession: Clinical psychologist
Theoretical approaches: Cognitive behavioral therapy; existential-humanist psychology
Specializations: OCD management, assessment, treatment, education, research
Other disorders: Tics, hoarding, post-traumatic stress disorder
Clientele: Adolescents, adults, elderly
Languages: French, English

Martin, Annick

Address: 7691A Boul Lasalle Montréal
Telephone: 514 595-8083
Email: annick_martin@hotmail.com
Profession: Clinical psychologist
Theoretical approaches: Cognitive behavioral therapy; psychopharmacology
Specializations: OCD management, assessment, treatment, education
Other disorders: Tics, hoarding, habit disorders, hypochondria, and eating disorders
Clientele: Children, adolescents, adults, elderly
Languages: French, English

Miller, Sydney B.

Address: 85 Roxton Cres Montreal Ouest
Telephone: 514 483-4621
Email: drsmiller@sympatico.ca
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: Assessment, treatment, education
Other disorders: Hoarding, hypochondria
Clientele: Adolescents, adults, elderly
Language: English, French

O'Connor, Kieron

Address: 7331 Rue Hochelaga Montréal
Telephone: 514 251-4015 extension 2343
Email: kieron.oconnor@umontreal.ca
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: OCD management, assessment, education, treatment, research
Other disorders: Tics, habit disorders, hoarding, hypochondria, body dysmorphic disorder, delusional disorders
Clientele: Adults, adolescents
Language: English, French

Pélissier, Marie-Claude

Address: 1940 Boul Henri-Bourassa E Suite 311 Montréal
Telephone: 514 575-2644
Email: mcpelissier@gmail.com
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: Assessment treatment, advice/support, education, research
Other disorders: Tics, habit disorders, hoarding, trichotillomania
Clientele: Adults
Languages: French, English

Prokop, Christopher

Address: Medi-Centre de Montréal West, 31 Av Westminster Montréal Ouest
Telephone: 514 949-3774
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: Treatment, research
Clientele: Adults
Languages: French, English

Radomsky, Adam S.

Address: 4115 Rue Sherbrooke O Suite 410 Westmount
Telephone: 514 738-3732
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: OCD management, assessment, education, treatment, research
Other disorders: Tics, habit disorders, hoarding, hypochondria, anxiety disorders, phobias, mood disorders
Clientele: Adults
Language: English

Rivard, Éliane

Address: 2100 Av de Marlowe Suite 616 Montréal
Telephone: 514 214-8478
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: OCD management, assessment, treatment
Other disorders: Habit disorders, tics, gambling
Clientele: Adults
Language: English, french

Taillon Annie

Address: 4915 Rue de Salaberry Suite 103 Montréal
Telephone: 514 727-5395
Email: taillon.annie@gmail.com
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: OCD management, assessment, treatment, education, research
Other disorders: Spectrum of OCD disorders, anxiety and mood disorders
Clientele: Adults, adolescents (16 years old and over)
Languages: French, English

Viezel, Magda

Address: 5025 Rue Sherbrooke O Westmount
Telephone: 514 983-8575
Email: mviezel@gmail.com
Profession: Clinical psychologist
Theoretical approach: Cognitive behavioral therapy
Specializations: OCD management, assessment, treatment, advice/support
Other disorders: Habit disorders, hoarding, hypochondria
Clientele: Children, adolescents, adults, elderly
Language: English

Québec

Centre de traitement de l'anxiété

Address:1990 Rue Cyrille-Duquet Suite 200 Québec
Telephone: 418 683-2303
Email: cta@qc.aira.com
Site web: www.centretraitementanxiete.com
Theoretical approach: Cognitive behavioral therapy
Specializations: Assessment, treatment
Other disorders: Anxiety disorders, hypochondria, habit disorders

South shore

Fortier, Christiane

Address: 28 Av Argyle Saint-Lambert
Telephone: 514 582-0594
Email: psy@christianefortier.com
Profession: Clinical psychologist
Specializations: OCD management, assessment, treatment, advice/support, education, anxiety disorders, mood disorders
Other disorders: Hoarding, hypochondria
Clientele: Adults, elderly, adolescents
Language: French

Organizations and support groups

Crisis line (Monday to Thursday from 9am to 9pm)
514 276-3015 or 1-866-922-0002
http://www.phobies-zero.qc.ca/

Phobies-Zéro

Services available

- Support groups in the following cities: Montréal, Québec (Limoilou), Québec (Ste-Foy), Repentigny, Saint-Hubert, Saint-Jérôme, Verdun, Sainte-Julie.
- Blainville: Monday 7h30pm-9h30pm Price: $5
  (421A Boulevard Curé-Labelle Blainville)
- Laval (Chomedey): Tuesday 7h30pm-9h30pm
  (3781 Boulevard Lévesque O Laval)
- Lévis: Monday 7h30pm-9h30pm Price: $5
  (5905 Rue Saint-Georges Lévis)
  Annual membership $20

6875 Boul Décarie Suite 300 Montréal, QC H3W 3E4
514 486-1448 or 1-877-303-0264
http://amiquebec.org/
info@amiquebec.org

Amiquébec

Services available

- Support groups : Monday 7h00pm-8h30pm
  (4333 Ch de la Côte-Sainte-Catherine Montréal)
- Open to families, friends and to people who has mental illness.
- Others programs are available.
- Visit the website for information.

Association québécoise des parents et amis de la personne atteinte de maladie mentale
1260 Rue Sainte-Catherine E Suite 208 Montréal, QC H2L 2H2
514 524-7131
http://www.aqpamm.ca/qui-sommes-nous/

AQPAMM

Clientele: It caters especially to parents and friends of a person who has mental illness, diagnosed or not.

Services available

- Support groups for parents and friends: reservation required 514-524-7131 (Visit the website for information).
- At the **CLSC Petite-Patrie** (Schedule available on the website)
  (6520 Rue de Saint Vallier Room 207 Montréal)
- At the **CLSC-CHSLD Pointe-Aux-Trembles**
  (Schedule available on the website)
  (13926 Rue Notre-Dame E Room 068 Montréal)

2226 Boul Henri-Bourassa E Suite 100 Montréal, QC H2B 1T3
514 334-1587
http://www.lacledeschamps.org/
lacle@lacledeschamps.org

La clé des champs

Services available

- Several workshops are available about various anxiety disorders like the obsessive-compulsive disorder.
- Many DVDs, CDs and books also available.

Centre d'études sur les troubles obsessionnels-compulsifs et les tics
Centre de recherche IUSMM, 7331 Rue Hochelaga Montréal, QC H1N 3V2
514 251-4015 extension 3585
tictactoc.org

CETOCT

Services available

- Support groups: First Thursday of each month at 7h00pm (December 4th).
- Clinical research project

5140 Rue St-Hubert Montréal, QC H2J 2Y3
514 738-4873 or 1-866-738-4873 (free) (Monday to Friday from 9h00am to 5h00pm)
http://revivre.org/
entraide@revivre.org

Revivre

Services available

- Support groups:
  Monday and Wednesday 1h30pm-3h00pm
  Monday 7h00pm-8h30pm Friday 9h30am -11h00am
- Visitors are not allowed.
  (Visit the website for information).

ALPABEM

Organisme communautaire de soutien aux familles et amis de la personne atteinte de maladie mentale
1772 Boul des Laurentides Laval, QC H7M 2P6
450 688-0541 or 1-888-688-0541 (free)
http://www.alpabem.qc.ca/
info@alpabem.qc.ca

Services available

- Many services available.

Foward House

2240 Av Girouard Montréal, QC H4A 3C3
514 488-9119
http://www.maisonlesetapes.org/
info@maisonlesetapes.org ou maisonlesetapes@videotron.ca
Clientele: Maison Les Étapes Inc./Forward House Inc. is a community organization offering services and programs to adults who had or has persistent mental disorders.

Services available

- Many services available.

La maison grise

La Maison grise de Montréal CP 123 Succ Rosemont Montréal, QC H1X 3B6
514 722-0009
http://www.lamaisongrise.org/index.htm
info@lamaisongrise.org
Clientele: For women from 25 to 65 years old.

Services available

- Accommodations and community services.
- Many others services available.

L'Autre Rive

925 Rue du Conseil Sherbrooke, QC J1G 1L6
819 564-0676
http://www.autre-rive.ca/index.php?section=joindre&page=joindre
lautrerive@abacom.com

Services available

- In a crisis situation we help the person with his more important needs; listening, medical accompanying if needed, we meet the person where he or she is. Each person that calls us is connected with a social worker as soon as possible.

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Répit « Une heure pour moi » Inc

750 16e Av Suite 10 Montréal, QC H1B 3M7
514 640-6030
repit@videotron.ca

Services available

- To prevent physical and emotional exhaustion of parents that lived with a child suffering from a mental disorder.

Centre d'entraide Le Pivot

3164 Boul Langelier Montréal, QC H1N 3A6
514 251-1869
celp@videotron.ca

Services available

- To contribute and promote healthy communication skills, to develop skills that maintain social rehabilitation, promote the autonomy and strengthen mental stability.

La lueur du phare de Lanaudière

676 Boul Manseau Joliette, QC J6E 3E6
450 752-4544 or 1-855-CRAQUER (272-7837)
lueurduphare@videotron.ca
Clientele: For the entourage of people that suffer from a mental disorder.

Services available

- Listening line, individual intervention, "exchange-coffee", workshop, conferences, documentation center, rest activities, etc.
- Our offices are open Monday to Friday from 8h30am to 12h00am and 1h00pm to 4h30pm.

Suivi communautaire Cyprès

8675 Rue Tellier Montréal, QC H1L 3A9
514 252-0444
http://www.rosac.ca/membres/servicesCommunautairesCypres.htm
sercomcypres@hotmail.com

Services available

- Individual follow-up in the living environnement is available. We help people that suffer from a mental disorder and want to improve their well-being and to evolve in their community.

Suivi communautaire le fil

755 Av du Mont-Royal E Montréal, QC H2J 1W8
We don't offer services at our offices.
514 525-0504
http://racorsm.com/membre/suivi-communautaire-le-fil
lefil@videotron.ca

Services available

- We offer support and we help people that suffer from a mental disorder to evolve in their living environment. We help them to develop social skills and to reach an emotional stability so they can live in a social and peaceful life.
- We help people that live in territory of the CSSS Jeanne Mance, Cœur de l'île and Saint-Michel Sud.

Diogène

Programme intervention et recherche Psychauses inc.
This program helps social reintegration.
514 874-1214
http://www.asrsq.ca/fr/membres/liste/membres_lis_06_dio.php
diogene@bellnet.ca

Services available

- Support people in many activities and projects; long term follow-up and proactive activities in correctional center.
- We offer support to marginal people, people that suffer from mental disorders, addiction and itinerant. Our goal is to stop the recurrence of their situation.

ANEB

Anorexie et Boulimie Québec
5500 Rte Transcanadienne Pointe-Claire, QC H9R 1B6
514 630-0907 or 1 800 630-0907 (free)
http://www.anebquebec.com/html/fr/accueil/accueil.html
info@anebquebec.com

Services available

- The mission of ANEB Québec is to help everyone that suffers from an eating disorder.

Tel Écoute / Tel Aînée

Tel-Écoute service: 514 493-4484
Volunteer's line: 514 493-4445
tel-ecoute@tel-ecoute.org
Tel-Aînés service: 514 353-2463 or 1 877 353-2460 (free)
Volunteer's line: 514 493-4445
tel-aines@tel-ecoute.org

Centre d'entraide Le Pivot

3164 Boul Langelier Montréal, QC H1N 3A6
514 251-1869
celp@videotron.ca

Services available

- To contribute and promote healthy communication skills, to develop skills that maintain social rehabilitation, promote the autonomy and strengthen mental stability.

Vers l'équilibre

4217 Rue Ontario E Montréal, QC H1V 1K2
514 251-1200
www.verslequilibre.ca
infovl@verslequilibre.ca

Services available

- Give a personal and relational demarche that promote the well-being of the person and maintain his/her emotional and psychological stability.

Les ateliers quatre saisons Inc

11929 Rue Victoria Montréal, QC H1B 2R1
514 640-4747
info@atelier4saisons.com

Services available

- Give occupational, therapeutic, personalized and structured workshop for adults that lived a psychiatric event and that suffer from persistent mental disorder.

Répit-Ressource de l'est de Montréal

7707 Rue Hochelaga Bureau 100 Montréal, QC H1L 2K4
514 353-1479
info@repit-ressource.com

Services available

- Service of rest for natural helper.

Entraide Saint Michel

3875A Boul Crémazie E Montréal, QC H1Z 2K9 (Entrance by the 20e Av)
514 593-7344
www.entraidesaintmichel.org
info@entraidesaintmichel.org

Services available

- Promote mutual aid, social and professional rehabilitation for people of 18 years old and more with mild, moderate and severe trouble.

Le murier Inc Volet travail

2615 Boulevard Pie-IX Montréal, QC H1V 2E8
514 254-6110
achayer@lemurier.org

Services available

- Service of accommodation and work learning for adults that suffer from diverse mental illness.

L'étincelle de l'amitié

7788A Rue Sherbrooke E Montréal, QC H1L 1A5
514 351-6473
www.etincelleamitie.org
info@etincelleamitie.org

Services available

- Mutual aid and social rehabilitation of person suffering of a mental illness by the exploration of various artistic activities.

L'art-rivé de jour Rivière-des-prairies

8178 Boulevard Maurice Duplessis Montréal, QC H1E 2Y5
514 648-4888
www.art-rive.qc.ca
info@art-rive.qc.ca

Services available

- Promote mutual aid and social rehabilitation with educative activities that promote self-development and the autonomy of the person.

L'alternative centre de jour

11813 Rue Notre-Dame E Montréal, QC H1B 2Y1
514 640-1200
www.lalternativecentredejour.org
lalternative@bellnet.ca

Services available

- Promote mutual aid and social rehabilitation with educational activities that promote a self-development and the autonomy of the person.

Parrainage civique de l'Est de l'Ile de Montréal

5797 Rue Hochelaga Montréal, QC H1N 1W6
514 255-1054
www.pceim.ca
info@pceim.ca

Services available

- Organization of social rehabilitation for people of 14 years old and more that suffer of a mental disorder or intellectual deficiencies.

Myths and reality

If I have OCD, I will suffer all my life.

NO. Vulnerability may persist, but the majority of people who receive behavioral therapy do not have the OCD throughout their lives.

All psychotherapies are similar.

NO. There are many forms of psychotherapy. However, cognitive behavioral therapy is the only to focus on learning practical techniques, specially adapted to situations of OCD, to regain control over his thoughts and behavior.

Continued on p.33

OCD is a form of madness.

NO. Most people with OCD are afraid of being crazy, but it is a fear, not reality.

Myths and reality

OCD is an anxiety disorder.

NO. In the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association in May 2013, the obsessive-compulsive disorder (OCD) has been removed from the anxiety disorders to form a new category of obsessive compulsive disorders spectrum.

OCD is very rare.

NO. We thought that it was the case until the 80s.

OCD is caused by a biochemical imbalance in the brain (serotonin).

YES, SEEMS TO BE TRUE FOR MANY.
This idea is based in large part, to the fact that drugs that are effective act on the serotonergic system.

The drugs known to be effective for the OCD are antidepressants acting on the serotonin system (a neurotransmitter in the brain).

YES. Luvox, Zoloft, Prozac and Paxil (drugs selective serotonin reuptake inhibitors -SSRI) have specific effects on the serotonin system. Anafranil and other IRS drugs have powerful effects on the serotonin system but also have effects on other neurotransmitters. Other drugs may be used in combination to increase or potentiate the effects of SSRI and IRS.

OCD reached as many men as women.

YES. This is one of the few psychological difficulties for which the prevalence is similar in both men and women.

OCD may appear at any age.

YES, MOSTLY. The majority of people with OCD have begun to have at least some symptoms before age of 40. Regarding children, the average of onset is 10 years.

I can lose control because of OCD.

NO. People with OCD are usually more in control than the average person.

We do not know the exact causes of OCD.

YES. We have several hypotheses. Several factors appear to contribute, but there is not a single cause. It is not necessary to know the exact causes of OCD to treat it effectively.

OCD is due to genetic factors.

PROBABLY YES, IN SOME CASES.
In approximately 50% of cases of OCD, another member of the family (i.e. Father or mother, brother or sister, grandparents, cousins, aunt or uncle) also suffers from this disorder. Genetic factors seem to play a role in some cases.

There are medications that can cure OCD.

YES, PARTIALLY. Many people are helped, but few are cured by medication. Improvements can range from little to much. For some, the OCD does not return when the drugs are stopped, but some report a return of symptoms. The behavioral therapy reduces the risk that the symptoms return.

Cognitive behavioral therapy is very demanding.

YES, PARTIALLY. Cognitive-behavioral therapy requires a greater involvement and effort. The therapist's role is to make the process less difficult as possible. The vast majority of people who are fully engaged in the therapy will succeed.

I can be dangerous because of OCD.

NO. People who have OCD are not more dangerous than people who have not.

OCD is caused by stress.

YES, IN MANY CASES.
Stress can worsen or may cause OCD, but it is never the only cause.

If I have already received cognitive-behavioral therapy without success, my chances to cure are lower.

NO. Some people do not come to the end of the OCD in a single therapy. Successful treatment depends on both the skill of the therapist, the degree of comfort and confidence you feel with this therapist, and your motivation to change. A first "failed" test is often due to the fact that it lacked one or more of these elements.

If a drug does not work for me, other drugs will not work either.

NO. We can't determine in advance what will be the best medicine for everyone. It is generally recommend trying several medications before said that pharmacological treatment is ineffective.

Cognitive behavioral therapy is the therapy of choice to treat OCD.

YES. Other forms of therapy can help people. However, cognitive behavioral therapy is the only efficiency that has been demonstrated repeatedly.

If the drugs do not work for me, behavioral therapy will not help me either.

NO. While medication and cognitive behavioral therapy both generate similar changes in the parts of the brain that appear to be overactive, does not respond to drugs does not mean that behavioral therapy does not work.

I am not Martha Stewart! History about OCD and Hoarding

By Christian Ducasse, M. Ed., research assitant for Projet International de Recherche Action Participative PIRAP[10]

I am a person who suffers from obsessive compulsive disorder and hoarding. In the text that follows, I relate the lessons I get from some life experiences with OCD and Hoarding. First, I will explain how inspirational messages like "I'm not Martha Stewart" and "I avoid avoiding" help me to do a job that normally I would avoid to do and lead me to taking action with an acceptable level of discomfort.

After the talk of Natalia Koszegi, psychologist, "Obsessive-compulsive disorder, real or fictional suffering?", it's made me realize that my imagination creates anxiety thoughts, but those thoughts are not the reality, and it is my duty to not give these thoughts too much!

Finally, you who suffer from OCD or Hoarding, you're less helpless as you think because you have experiential knowledge and many skills!

1. Successfully complete a task that I avoided it is possible! But under certain conditions:

With insight, I see that I have a subconscious goal when I have a job to do. I do writing work for PIRAP, cooking at home or emptying an overstocked room, etc. I have this drive and this thought: "I must do this task perfectly." Why perfectly? Undoubtedly, by doing so, it is impossible to criticize my work and my personally and I will protect my self-esteem and my own.

My inspirational messages and caregivers:

- "I'm not Martha Stewart"

By this idea, "I'm not Martha Stewart", Mrs. W. my social worker (now a happy retired) said: That people who suffered from OCD clean, makes food or uncluttered room, with the same expectations of "Martha" and an equally beauty than "Martha". This is an utopia because "Martha" has an army of people who are behind the camera to make the viewing experience "Martha Stewart" perfect.

In fact, "I'm not Martha Stewart" leads me to visualize a task not as a global whole (I have to clean everything and uncluttered the apartment immediately and perfectly), but as a set of small things to do. I can do step by step and respecting priorities. Sometimes when my family visits me, they met me close to my home and we share a good meal at the restaurant. Consequently, I no longer feel guilty, not being able to get them home.

- "I avoid avoiding" and "respect my ability to feel anxious respecting my level of exposure."

By this formula, Mrs. W. brought me the idea that the only avoidance that is really helping is: "I avoid avoiding." This idea brings me to take action without thinking too much and is very effective if before I took care to divide my task in realistic and measurable goals. Each task with a time-bound of fifteen to thirty minutes. Finally, this task has to make me live a level of anxiety that I am able to control.

2. In a situation of OCD or Hoarding, I imagine the worst and am convinced that "worst" is reality and will happen!

At a recent conference: **The obsessive compulsive disorder, real or fictional suffering?**[11] Mrs. Natalia Koszegi, psychologist specializing in OCD, said that the work of CETOCT have shown that individuals with OCD are afraid to do a bad thing in an actual concrete situation, as they say, since I think at something bad, I'll do it necessarily. They neglect to consider the evidence in the here and now as they rely more on their imagination. They ignore the reality.

So how many times I checked and rechecked that the heaters were turned off on my stove, my taps did not seek, my front door was closed, the evaluation report that I wrote and then given to my boss not include errors or blasphemies. So why such verification behavior?

[10] Pour plus d'information : http://www.pirap-ippar.com/

[11] Koszegi, Natalia. 2014. *Les troubles obsessionnels compulsifs, souffrance réelle ou fictive ?* Document téléaccessible à l'adresse suivante : http://www.iusmm.ca/documents/pdf/Institut/%C3%89v%C3%A8nements/TOC_conf_fernand_seguin.pdf (document consulté le 22 septembre 2014).

To avoid living unbearable consequences related to negligence on my part if inadvertently, I had not considered the possible disasters imagined.

In his lecture, Mrs. Koszegi gave us some solutions:

- Challenging beliefs and change the mechanisms that maintain our way of thinking and are responsible for our OCD;

- Challenging beliefs by questioning the overestimation of danger and its potential disastrous consequences;

- Challenging our perception of our responsibilities focusing on our real and not imagined, not apprehended responsibility;

- Change the way we think the typical OCD. Learn to rely on what is "there" and what is "real", while learning to avoid being overwhelmed by the possibilities and elements imagined of the order of the imagination.

Now, when I thought to go back and check, I am able to stop me and tell me that usually when a faucet or tap leak, I can see it. I think it's possible that my tap leak, but I choose not to check, because if my tap was leak, I would have closed it immediately.

3. You who suffer from OCD or hoarding, you have unsuspected skills!

At the recent ACFAS, I attended the conference: "The turn-patient partner what practices implement patient?[12]"Offered by Marie-Pascale Pomey, MD, Institute of Public Health Research, University of Montreal

Mrs. Pomey and his team have focused on the discovery that a patient develops skills in contact with chronic mental illness and showed how the patient established a partnership with the team of professionals responsible for the health care. Although studies are required to validate this point, I am able to recognize the same skills with my illness. A person who suffers from mood disorder has common point with a person who suffers from a chronic illness such as cancer, diabetes, arthritis, etc.

In 2013, researchers conducted interviews with patients living with a chronic illness. Following the analysis of the interviews, three skill categories have emerged. The first order of learning, a second order of evaluation and a third order of adaptation.

- **The practices of the order of learning:**

They are of two kinds. The first is the domain of knowledge. Patient partner knows his disease because he is interested in. He is able to document it by using internet, reading articles and assist presentations.

Second, the field of the art. Patient partner is able to use his experiential knowledge to learn and compare the techniques used by health professionals and the need to propose a technical change of care offered by a professional with a more appropriate intervention technique.

- **The practices of the order of evaluation:**

The interviews showed that the patient partner is able to use to evaluate the action to validate its appreciation of the work of a professional care. Professional care can be evaluated first for his scientific and medical knowledge, second for his technical expertise and third for his interpersonal skills. For example, if a patient is not satisfied with a care professional, he is able to communicate peacefully with him and change its behavior.

- **The practices of the order of the adaptation:**

The patient is able to evaluate the performance and the evaluation of a professional care, the partner patient will adapt and make choice.

[12] **Article accepté et à paraître:** Karazivan, Ph., Dumez, L., Flora, L., Pomey, M. P., Fernandez, N., Ghadiri, S., Del Grande, C., Jouet, E., Las Vernas, O., Lebel, P. (2014). ***The Patient as Partner in Care: Conceptual Grounds for a Necessary Transition.***

For example, make the choice to leave the professional responsibility to take care of him. At other times, the patient care partner deems it is better to pick and choose another health professional care who entrust their health. Interestingly, the researchers found that mutual care partnership applies to the patient even if the professional care does not value a partnership of mutual care between him and the patient.

In conclusion, Madam Pomey partner indicates that the patient learns and documents to better understand the disease. Then he is able to assess the skills of professional care, assess and adapt its communication with the professional care to promote information sharing. He is able to use his experiential knowledge to discuss technical care with the nursing professional. Even the quality of these relationships and the interactions with the health care team will be evaluated and may be subject to adjustment. Patient partner may choose not to join a proposed professional treatment or not to engage and continue the shopping.

Specifically, I work on my OCD and my hoarding with a psychotherapist who uses the acceptance and commitment therapy. I never doubted the competence of my therapist or the therapy. But onetime, I expressed to my therapist my misunderstanding of the vocabulary he used to let me know the strategies and analogies of ACT. It was like he speaks "Klingon".

My communication with my therapist allows him to adapt his vocabulary as well as its communication to promote my understanding. For my part, I made an effort to inform me a little and try to understand the concepts specific to the ACT therapy. As a result, now I enjoy the teaching of my psychotherapist.

In conclusion, you have a lot more skills than you think to improve your situation. Also, be indulgent with professional who help you. You probably know better your health, but professionals ask only to learn from you!

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