

INTRUSIVE THOUGHTS

A NEWSLETTER FROM THE DEPARTMENT OF PSYCHIATRY'S OCD CARE TEAM

KNOWING BETTER AND DOING BETTER – LESSONS IN CAPACITY

On a Monday of last year, I slowly backed out of a slanted parking space at my dermatologist's office. I was thinking, "Focus. The car next to you is parked at a weird angle. It's not parallel. Go slow. Curve the angle. Make sure you go around it. Don't scrape it." I looked intently out of the passenger window as I turned that gray leather steering wheel with my cold right hand. I felt the thin edge of my seatbelt digging into my abdomen, my heated seats, and my foot gently pressing the gas pedal. A millisecond later, I heard the unfortunate crunch of cracking plastic from behind me and was pushed forward as my SUV bounced off the solid steel bumper of a powder blue Ford F-250 work truck. I exhaled slowly with audible commentary on my performance. "Seriously?!" I grumbled as I rolled my eyes. I wasn't scared, just exasperated that I'd focused so heavily on my passenger window I failed to attend to my rear-view camera.

I was aware of the truck's presence, sticking out of the too-small parking space with lines that were painted before super-sized everything became a thing. When I first parked, I'd even considered moving my car because of this behemoth of a truck behind my vehicle on the opposing row. I had reminded myself to be careful leaving not to hit it. I knew that truck was there, forgot, and then bumped it when I momentarily forgot to follow the most basic driving safety guidelines. I knew better, but didn't do better.

The above was an accident, but honestly, I've had a multitude of times in my life where I've known better but didn't do better – I have knowingly made choices that are inconsistent with my values to avoid or remit pain and discomfort, and responded impulsively out of my own frustration, judgment, and impatience. More than I care to admit, I've known what I've needed to do but could not get myself to do it.

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Department of Psychiatry

SCHOOL OF MEDICINE

UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS



Have you ever known better but didn't do better?

If we are honest with ourselves, we can likely think of countless times we knew better but didn't do better. Given the right circumstances, most of us crash head-first (or bumper first) into our own humanity – we realize that we are capable of the worst on our worst days. Sometimes we spend seasons, years, or decades in a continual state of wanting to do better but not living up to our visions of becoming our best selves.

It is humbling and hard to be a human.

It is easy to feel shame when we oversimplify our capacity to perform. However, it can be helpful to consider the following analogy: we are all walking up the mountain-of-life, carrying a proverbial “backpack of stuff” that changes in weight because of what is happening around us and within us. This affects our speed, fitness, wellness, pain, and balance. It also affects how easily we can interact with others on the mountain and how well we can make the jumps and maneuvers that we need or want to when things get rocky. It is easy to assume that trying harder is all we need to “do better,” but we forget that a backpack full of rocks is heavier than a backpack carrying a couple of pebbles.

Capacity is defined as “the maximum amount that something can contain or produce” and therefore determines what we are able to do at any given time. Our capacity changes from day to day or hour to hour based on how heavy your backpack is. Your “best” one day might be entirely different than your “best” the next day. If you find yourself thinking that you “should have done things differently,” or feel confused about how you could have made a choice that you never thought you were capable of, it can be important to consider what your capacity truly was at that time—emotionally, physically, mentally, spiritually, financially, etc. Were you truly capable of doing better? Or do you simply wish that you were?



Curiosity about our capacity can build understanding of the various factors that keep us stuck in “knowing better” but feeling immobilized to “do better.” Importantly, curiosity and understanding do not endorse or excuse poor choices. Counterintuitively, they aid us in developing self-compassion that unshackles the shame that shackles us. We gain freedom when we learn to look at our failures through the eyes of curiosity and compassion.

This is where the tough work begins—

- Without criticism, can you begin to be curious about what led to a decision or season that was sub-optimal?
- Can you make space to believe the duality that you may have been doing your best even if you made a mistake/bad choice or wish you could have done things differently?
- Can you begin to give yourself grace for how your “best” changes based on the other things you carry?
- Can you simultaneously hold yourself accountable to make improvements and gain healing in areas where there is dysfunction that lowers your capacity?
- Can you begin to kindly say to yourself, “Today’s best wasn’t as good as yesterday’s best, and I hope my “best” tomorrow is better.”
- Can you begin to believe these things are true for other people too?

Remember, a backpack full of rocks is heavier than one with a few pebbles—that’s capacity. Remember this for yourself and for everyone else. Do the things necessary to unpack your backpack. Be kind to yourself and to others, everyone’s capacity is different and changing just like yours! 😊

Sincerely,

Dr. Abigail Norouzinia and The OCD Program Team



Coming March 4, 2024

The University of Colorado
Anschutz Medical Campus
OCD and Anxiety Intensive Outpatient Program
3-days a week
9am-12pm

We will be taking Aetna, Anthem,
Cigna, Colorado Access Medicaid, and Colorado
Community Health Alliance Medicaid

Get the referral process started
by emailing our admin staff at
smhservice@ucdenver.edu

Questions? Email Emily.Hemendinger@CUAnschutz.edu

OUR TEAM

- *Dr. Rachel Davis MD - Medical Director and Psychiatrist*
- *Emily Hemendinger LCSW, MPH, CPH, ACS – Clinical Director/Licensed Clinical Social Worker and DBS Coordinator*
- *Dr. Stephanie Lehto PsyD – OCD Therapist/Licensed Psychologist*
- *Dr. Abigail Norouzinia PhD – OCD Therapist/Licensed Clinical Psychologist*
- *Kasey Benedict LCSW -OCD Therapist/Licensed Clinical Social Worker*
- *Dr. Alyssa Tran DO -- Psychiatrist*
- *Dr. Jake Gadbow MD - Psychiatrist*
- *Katie Sinsko MSW -- Social Work Fellow/IOP Therapist*
- *Alie Garza LCSW -- IOP Care Coordinator/Licensed Clinical Social Worker*
- *Orah Fireman, LCSW, MEd -- IOP Behavioral Health Specialist/Licensed Clinical Social Worker*
- *Harper Gillard -- MSW candidate and social work intern*
- *Erin LeBeau --MSW candidate and social work intern*
- *Interested in contributing to the newsletter? Email the editor at Emily.Hemendinger@CUAnschutz.edu*



STAFF SPOTLIGHT: KATIE SINSKO

Katie completed her Masters in Social Work at the University of Denver in 2023 and was previously the social work intern/trainee with the OCD Program from 2022-2023. In fall 2023 she started as the program's Faculty and Social Work Fellow/IOP therapist. Katie currently holds a state permit and is working towards her licensure in clinical social work. She began research in the mental health field 7 years ago, focusing on factors related to depression, trauma, and suicidality. This was a foundational element in the development of a trauma-informed perspective when working with mental health concerns. Since beginning clinical work, she has expanded her focus to include obsessive-compulsive disorder, anxiety disorders, eating disorders, and self-image to her research and clinical efforts. In her free time, she enjoys outdoor climbing, skiing, and hiking - all things related to the great outdoors! She also enjoys spending time reading, writing, and painting as creative and expressive outlets.

GROUP OFFERINGS

*Mondays at 4pm (monthly)
Intro to ERP - for new group members*

*Mondays at 5pm
For adults ages 18+ with OCD and related disorders*

*Tuesdays at 5pm
For adults ages 18+ with OCD and related disorders*

*Wednesdays at 5pm
For adults ages 18+ with OCD and related disorders*

*Thursdays at 4pm
For adults ages 18+ with OCD and related disorders*

Our adolescent group is no longer offered

We do have a waitlist for individual and group therapy, please reach out to be added to our waitlist and/or send you other referrals.

Are you a clinician who wants to know more about OCD and ERP? We offer trainings, consultations, and supervisions!

[CLICK HERE FOR MORE RESOURCES ON OCD AND ERP FOR CLINICIANS AND PATIENTS](#)

EATING DISORDERS AND OCD: BIRDS OF THE SAME FEATHER?

By Emily Hemendinger

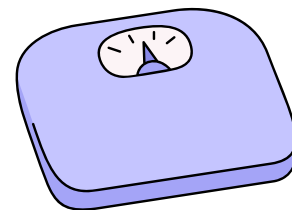
Eating disorders and OCD commonly occur together and can present similarly. There are genetic links between these disorders, as well as shared contributing and maintaining factors. Both also do not have one single cause, are often misunderstood and stigmatized, and cause significant distress and impairment.. However, there are also several key differences in conceptualizing and treating these conditions.

Read more below for some common similarities and differences.

SIMILARITIES

- Manifestations of anxiety
- Involve distressing and sticky intrusive thoughts
- Over-value thoughts
- Time consuming
- Negative impact on mental and physical health
- Typically involve shame, guilt, hyper-responsibility, and magical thinking
- Reassurance seeking and accommodation are common
- Avoidance maintains both disorders
- Treatment for both involves a combination of cognitive and behavioral therapy, focused on reducing avoidance
- Medication is part of treatment for both disorders

- Common shared traits:
 - Perfectionism
 - Rigidity
 - Low distress tolerance
 - Concern about making mistakes
 - Conscientiousness
 - Rule followers

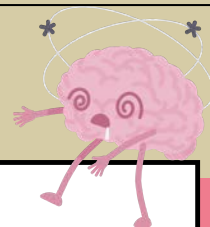


PERFECT

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DIFFERENCES



- OCD symptoms are ego dystonic, meaning that the symptoms conflict with a person and their values.
- Generally, eating disorder symptoms are ego syntonic, which means these thoughts are not always viewed as problematic and often maintain the disorder. Made more complicated by the reinforcement of diet culture and the thin ideal.
- People with eating disorders, except for those with ARFID, have body image distortion and distress. People with OCD may have body image concerns, but this is not necessary for a diagnosis.
- People with OCD may also have symptoms related to food that have nothing to do with an eating disorder. For example, someone may avoid certain foods for fear of getting sick, contamination concerns, intense feelings of disgust, or related to scrupulosity.
- People with EDs have symptoms related to food, weight, and appearance. In order for someone with an ED to be diagnosed additionally with OCD, they must have at least one other obsession that is unrelated to food and appearance.
- Treatment for OCD typically involves ERP as a frontline treatment, along other cognitive and behavioral interventions.
- Treatment for EDs is focused more on identifying and reworking one's relationship to unhelpful thoughts and beliefs with a combination of cognitive and behavioral, interpersonal, and experiential interventions. ERP is often an add-on therapy or secondary treatment.

WHAT'S THE FUNCTION?



It can be helpful to ask ourselves “what’s the function” when it comes to determining if something is related to the OCD or ED. Other questions to consider are, “why are your obsessions distressing to you? What is leading to performing compulsions? What is the feared outcome?”



COMPARISON

By Stephanie Lehto

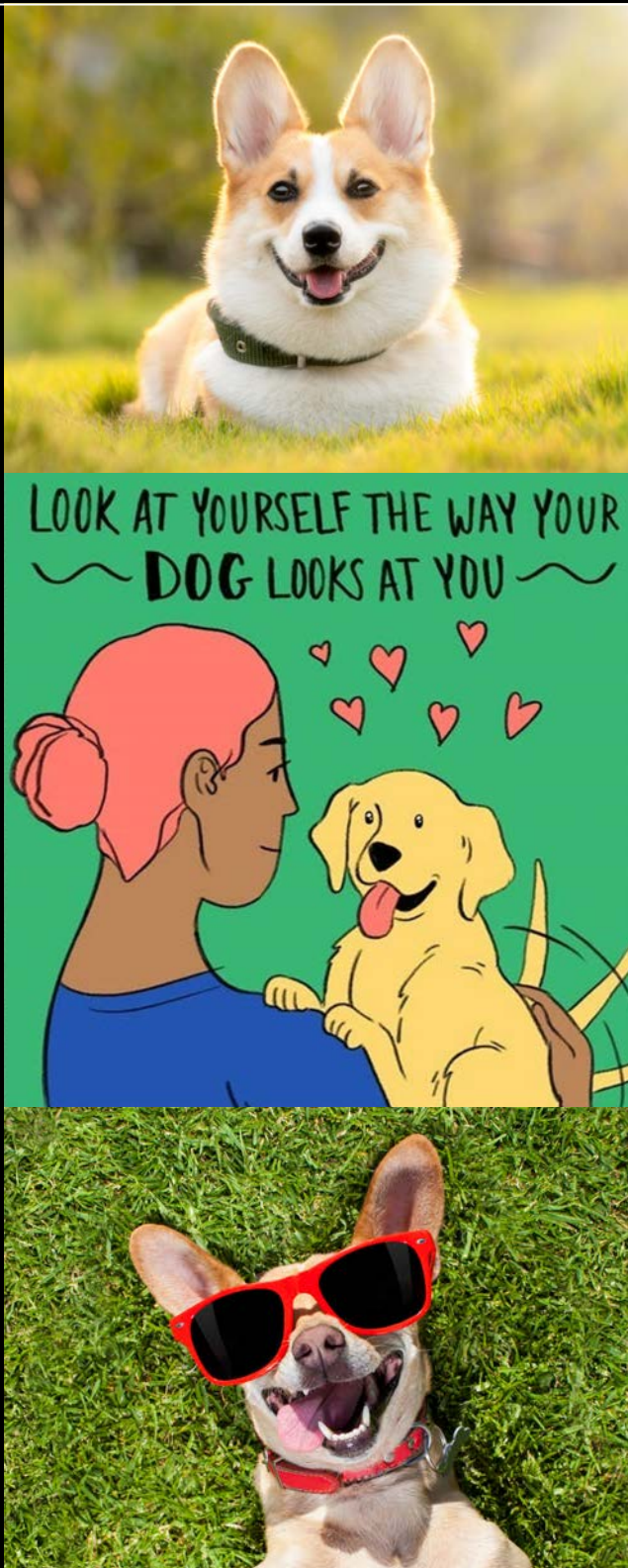
You've probably heard some variation of the saying "comparison is the thief of joy," which is true, but oftentimes does not emphasize the role of comparison for us. Social Comparison Theory (Festinger, 1954) suggests that people use comparison to assess how we are doing and change our behavior if there are differences from our comparison source. There are three forms of comparison: upward social comparison, downward social comparison, and lateral social comparison. When engaging in an upward social comparison, one compares themselves to someone who is "better off." Downward social comparison is when we compare ourselves to someone who is not as good as us, and lateral social comparison is when we compare with someone who is essentially even with us.

For individuals with eating disorders or eating disorder behaviors (EDBs) the social comparison is often upward social comparison to the thin ideal. Social media (particularly Instagram) and celebrities are common sources of upward social comparisons (Brown & Tiggemann, 2022; Pedalino & Camerini, 2022).

These upward social comparisons can lead to body dissatisfaction, and these types of comparisons predict lower self-esteem which predicts EDBs (Corning et al., 2006). While upward social comparisons occur on social media, these comparisons can also occur in real time with our friends, family, and colleagues—and for more than body image!

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Sometimes, we experience a filter for our surroundings and notice those who are “better off” than us and do not notice those who are the same as us, which can lead to isolation. Ideally, we can learn to notice comparison as it is happening and practice our different coping strategies (check the facts, positive self-statements, defusion, and so on). However, it’s not as easy as it sounds.

Additional strategies to help with comparisons and help improve body image can include neutral statements (“I have legs”) and functional statements (“My legs help me walk my dog”). Following the body positivity movement may also help, while recognizing that it is really hard to move from “I hate my body” to “I love my body.” Practicing flexibility and giving ourselves grace that body positivity does not happen overnight and that we can still struggle even if we are learning to love our bodies can help with this. It is also important to recognize the role of idealized photos and edited photos to critically evaluate the body related content (Pedalino & Camerini, 2022). Social media has options to mute accounts or filter for words in a post, which may be a helpful way to create some barriers for comparisons.

References:

- Brown, Z., & Tiggemann, M. (2022). Celebrity influence on body image and eating disorders: A review. *Journal of Health Psychology, 27*(5), 1233-1251.
- Corning, A. F., Krumm, A. J., & Smitham, L. A. (2006). Differential social comparison processes in women with and without eating disorder symptoms. *Journal of Counseling Psychology, 53*(3), 338.
- Festinger, L. (1954). A theory of social comparison processes. *Human Relations, 7*, 117-140. <https://doi.org/10.1177/001872675400700202>
- Pedalino, F., & Camerini, A. L. (2022). Instagram use and body dissatisfaction: The mediating role of upward social comparison with peers and influencers among young females. *International journal of environmental research and public health, 19*(3), 1543.

SPORTS AND EATING DISORDERS ARE INTERCONNECTED

By: Bella Evan Cook

The relationship between sports and eating disorders is complex and multifaceted. While participation in sports can promote physical health, discipline, and teamwork, certain factors within the sports culture may contribute to the development or exacerbation of eating disorders. The prevalence of eating disorders among athletes can vary depending on the type of sport, the level of competition, and individual factors. Certain sports that emphasize weight, appearance, or performance in weight-class categories may pose a higher risk for the development of eating disorders.

Here are some key considerations: Sports that emphasize athletics such as figure skating, dance, gymnastics, running, diving/swimming, may have a higher prevalence of eating disorders. Athletes in these types of sports may face pressure to maintain specific body shapes or sizes, leading to disordered eating behaviors. Weight-class and endurance sports such as wrestling and rowing, may cause athletes to engage in extreme weight-cutting practices, which can contribute to disordered eating. Endurance sports, where lower body weight is often associated with better performance such as running, may also be associated with

a higher risk of eating disorders. The pressure to perform can contribute to body image concerns and eating disorder behaviors.

Additionally, female athletes may face unique challenges related to societal beauty standards especially in sports where aesthetics are heavily emphasized. Male athletes can also experience body image pressures, particularly in sports where weight or appearance is a significant factor. Eating disorders are dangerous and can sabotage sporting success and seriously impair an athletes' physical and mental health. Lastly, the team culture, coaching styles and expectations within a sport environment can influence the prevalence of eating disorders. Coaches who put an emphasis on weight over healthy performance may contribute to unhealthy behaviors.

It's important to note that while certain sports may be associated with a higher risk, athletes across all sports and levels of competition can be vulnerable to eating disorders. Additionally, individual factors, such as personality, psychological well-being, and external pressures, contribute to an athlete's risk.



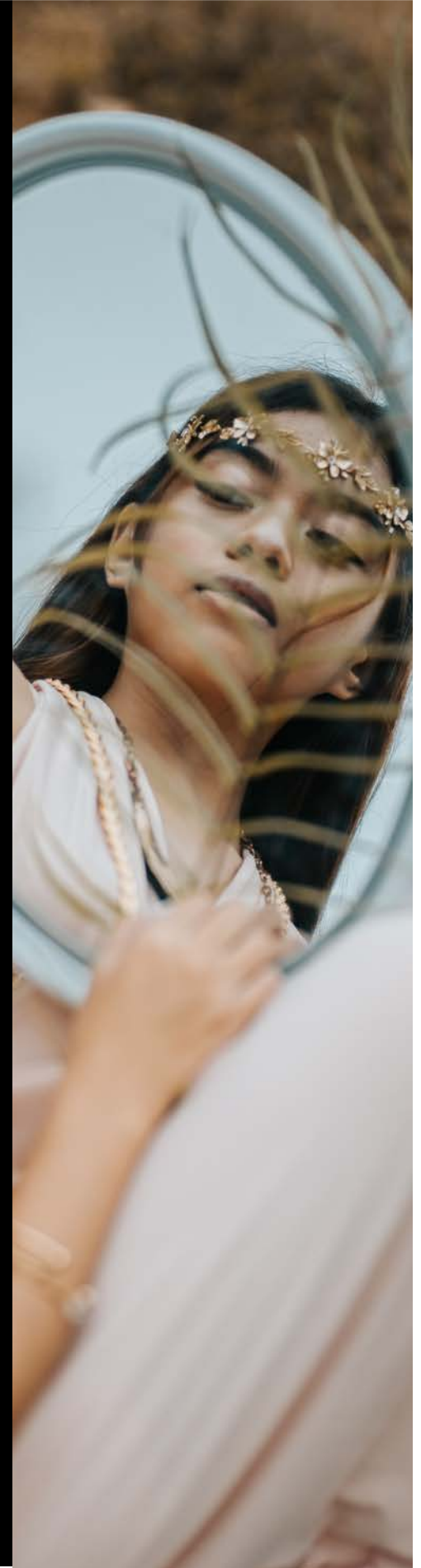
BODY DYSMORPHIC DISORDER

By Erin LeBeau and Harper Gillard

Body dysmorphic disorder (BDD) is a category within the obsessive-compulsive umbrella wherein individuals are preoccupied with specific parts of their body and believe them to be misshapen, disproportionate, wrong, or ugly. Some of the more common preoccupations are around acne, blemishes, hair loss or facial hair, teeth whiteness, nose sizes, hip shape, face shape, or spots. Oftentimes, others will not agree that the “defect” exists. Despite reassurance or evidence to the contrary, these thoughts become obsessive, which separates BDD from ordinary dissatisfaction with the body.

The most common compulsions that manifest for people with BDD are camouflaging (e.g. curling into a ball, heavily using makeup, and covering up with clothing and accessories), excessive surgeries and treatments, frequently checking body parts in the mirror (otherwise called “body-checking”), avoidance, and reassurance-seeking from others. Treatment focuses on improving self-esteem and self-worth. Exposure Response Prevention involves decreasing avoidant or compulsive behaviors. Some examples of exposures for BDD are listed below:

- Wear new clothing items
- Wear old clothing items you haven't worn in awhile
- Decrease the amount of supplements you take
- Go to a social event that you wouldn't normally go to
- Change in a dressing room
- Take public transport
- Go to the grocery store without makeup
- Go somewhere without a hat
- Set a timer for time you spend looking at yourself in the mirror
- Post a selfie online without editing it





DEATH BY DECAF

By Alie Garza

In the world of OCD, I like to say that “if you can think it, OCD can latch onto it”. Nothing is off limits when it comes to OCD, and it’s far from uncommon to see OCD develop fears around food. One example of this is how my own OCD latched onto caffeine years ago.

Let me start this by saying, that drinking iced coffee is a very strong value-based activity of mine. After spending 6 years in the Pacific Northwest, I don’t think it would be a stretch to say it’s become one of my very few hobbies. I’m sure at some point in life you’ve read or heard something about caffeine and anxiety, as I have many times. So when I had a major flare-up of OCD, Health Anxiety and Panic Disorder symptoms in 2020, it wasn’t long before caffeine got put on the chopping block.

I had some very consistent fears popping up for me including a hyperawareness of my heartbeat. This hyperawareness would lead to an increase in anxiety, the increase in anxiety would lead to an increase in awareness, and of course, as these things both increased so

did the firm belief that something was terribly wrong. As dread of these episodes increased (along with the frequency of ER trips), my anxiety decided I needed to do something to prevent it. So, when assessing the options, caffeine was the first to come to mind.

I decided that caffeine was not worth the risk and went down to half-caffeine. But if you give OCD/anxiety an inch, it will take a mile. So that became too risky, and turned into only drinking decaf. And then drinking decaf became too risky and became no form of coffee at all. So, then, I switched to hot chocolate. But, I decided that was too risky.

My anxiety started to wonder “What else contains caffeine?”. So, the next step for my OCD was to bookmark a caffeine calculator website and look up everything I ate. What started as a standard recommendation of reducing caffeine intake, OCD took to a clinically impairing obsessively avoidant degree, as it does best.

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It can be easy for OCD to disguise itself as taking “responsible precautions” and things such as food/drink are especially susceptible in our culture that is flooded with countless opinions, fads, “cures” and solutions that are fueled by diet culture. It’s not uncommon for obsessive and compulsive behavior to in fact be praised and described as doing what’s “healthy”. When I had cut every type of beverage out of my diet, due to OCD fears and avoidance, I was often praised for just drinking water and told how good that was for me. What was not understood, even by myself, at the time, was that this was far from a healthy choice, it was OCD’s choice.

When I finally started ERP, caffeine was one of the first things that I wanted to take on. Sitting in coffee shops in Portland had been stolen from my life by OCD and I wanted it back.

I will never forget the first exposure that I did related to this. I walked down to a coffee shop with some peers and someone went in to order me a decaf iced vanilla latte. When they came out there was no writing on the side of the cup, and OCD was not pleased. *What if they forgot to make it decaf? What if this is full-caff?*

What if I have a heart episode? What even is the nearest ER to here? How will I know if I’m going to die? I’ll these fears were directed at a 12 oz plastic cup as I stood outside the coffee shop panicking and crying.

However, I was ready to have my life back. OCD had me convinced I was going to die at that moment, but for the sake of freedom, I was willing to lean into that fear and say, “I guess we will see.”

Whether it’s the fear of caffeine causing a heart attack, or that you’ve suddenly developed an allergy to peanuts (after 27 years of no allergy, another one of my OCD’s favorites), or that a piece of food has been contaminated and will make you sick, or that you might forget how to chew and choke while eating... OCD is extraordinarily creative and sneaky. So every time I take a sip of coffee, as I have throughout writing this, it’s so much more than just a drink to me. It’s a reminder that OCD/Health Anxiety/Panic Disorder doesn’t get to call the shots in my life anymore. My daily iced vanilla latte is a nod to the freedom the ERP therapy and my tenacious spirit took back, one sip (and many tears along the way) at a time.



SELF-COMPASSION

By Kasey Benedict

It has been a very long day and I am tired. Nothing extraordinary has happened, but a seemingly endless parade of stressors has worn me down. I am a parent to two small children though, and so I trudge on through my evening, counting down the minutes until they are asleep and I can have a break. I'm working hard to stay calm, to stay patient, to be the parent I want to be. With gritted teeth I manage to remain placid (at least on the outside) through the afternoon, through dinner, until finally I can't take it anymore. There are too many people talking to me at once, needing something from me, touching me, and finally I snap. "Get off of me" I scream as both of my kids argue for space in my lap. My older son jumps away, and I see his eyes widen in fear. I instantly feel a double layer of guilt (layer one for yelling and layer two for being the type of parent who feels so overwhelmed that she needs to yell in the first place). My stomach hurts and my chest feels heavy.

Rewind the tape to a very similar scene 3 years ago. This time though, that terrible feeling I have when I lose my patience with my kids (probably a combination of anger, shame, and overwhelm) immediately triggers a barrage of self-criticism and an entry point into my OCD cycle. My mind is inundated by thoughts that I am an unfit parent, that I have ruined my attachment to my child, that there must be something wrong with my child for him to have overwhelmed me in the first place.

A need to ensure that nothing like this ever happens again takes over and I begin to compulsively consume parenting podcasts and books. I look over my notes from the developmental psychology class that I took as an undergraduate. I want to hug him and tell him that I love him (a lot). I try very hard to figure out how to manage my child's behaviors as well as my own emotions. On and on this cycle goes until one day I begin to read a book titled *Self Compassion*.

In her book, Dr. Kristen Neff defines self-compassion as when "we are kind and understanding rather than harshly self-critical when we fail, make mistakes, or feel inadequate. We give ourselves support and encouragement rather than being cold and judgmental when challenges and difficulty arise in our lives."

As a therapist this is slightly embarrassing to admit, but this was a revelation to me. The idea that I could be kind to myself when I made a mistake was truly radical, and I'm not exaggerating when I say that it changed my life.



Through reading her book and completing two self-compassion trainings I learned how to cultivate a new way of relating to myself when I (inevitably) experience challenging emotions and when I make mistakes.

Exposure and response prevention (ERP) is the gold standard for treating obsessive compulsive disorder. In ERP, we essentially expose ourselves to something that we know will trigger our obsessions (in my case that I am a terrible parent, will harm my child, and/or that there is something wrong with him) and then prevent our typical responses (listening to podcasts, reading books about parenting, hugging my kids, telling them I love them, and lots and lots of ruminating). It's not enough to just prevent our compulsions however, we must learn to do something else instead. For me, and for many of my patients, this is where self-compassion comes in.

According to Dr. Neff, self-compassion has three components:

1. Mindfulness: being open to the present moment's reality
2. Self kindness: choosing to soothe and comfort ourselves when external life circumstances are challenging and feel too difficult to bear
3. Connection to common humanity: recognizing that all humans are flawed works-in-progress, that everyone fails, makes mistakes, and experiences hardship in life



Fast forward to my recent evening screaming at my kids to “get off of me.” I still feel anger and guilt and overwhelm in moments such as these. My first instinct is still to look for that magical podcast that can tell me how to be a perfect parent. But now I have learned how to use the three components of self-compassion as response prevention in order to practice staying out of my OCD cycle. It might sound something like this. “Woah, I’m feeling really overwhelmed and guilty right now”-mindfulness. “It’s really hard to be a parent sometimes. That was a rough day and I’m feeling really burned out. This is really hard”-self kindness. “Mistakes are part of life for everyone. No one can stay calm and patient all of the time.”-connection to common humanity.

For me, self-compassion has proven to be a powerful response prevention tool. It gives me the grace to be a messy, imperfect human so that I can more quickly move through my challenging experiences and return to the things in my life that are most important. My hope in sharing part of my story is that it can help others cultivate a similar sense of grace as a way to disrupt their OCD cycles too.



OCD PROGRAM HAPPENINGS

On January 10, 2024, the OCD Program had our winter team retreat. The team met up in downtown Denver to efficiently put together 30 care packages for people experiencing homelessness. After a morning of handing out care packages, the team warmed up at Pho-Natic for some tasty lunch!



RESOURCES

Below is a list of websites and resources for individuals with Eating Disorders:

- **The Eating Disorder Foundation:**
 - URL: <https://eatingdisorderfoundation.org/>
- **Eating Disorders Anonymous:**
 - URL: <http://www.eatingdisordersanonymous.org/>
- **The National Association of Anorexia Nervosa and Associated Disorders:**
 - URL: <http://www.anad.org/>
- **Eating Disorders Helpline:**
 - (888) 375-7767
 - Email: hello@anad.org
- **Eating Disorder Referral and Information Center:**
 - URL: <http://www.edreferral.com/>
- **National Eating Disorder Association**
 - URL: <https://www.nationaleatingdisorders.org/>
- **National Alliance for Eating Disorders helpline:**
 - [\(866\) 662-1235](tel:8666621235)
- **Diabulimia Helpline:**
 - [\(425\) 985-3635](tel:4259853635)
- **National Eating Disorder Information Center**
 - URL: <http://www.nedic.ca/>
 - Helpline: (866) NEDIC-20; (416) 340-4156
 - Email: nedic@unh.ca



Match the pet(s) with the OCD Program owner.
One owner may have more than one pet but not vice versa!

(1) Katie Sinsko



(2) Orah Fireman



(3) Rachel Davis



(4) Alie Garza



(5) Alyssa Tran



(6) Emily Hemendinger



(7) Kasey Benedict



(8) Stephanie Lehto



(9) Jake Gadbow



(10) Erin LeBeau



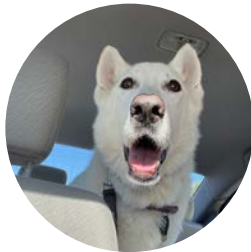
(a) Chula



(b) Misty



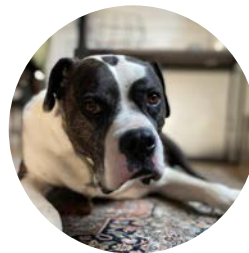
(c) Loki



(d) Roly Poly



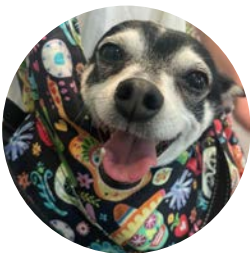
(e) Mosley



(f) Rubie



(g) Teddie



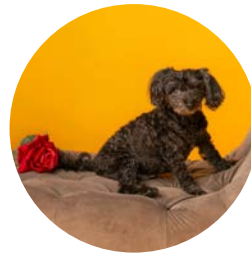
(h) Wizard



(i) Gracie



(j) Moxie



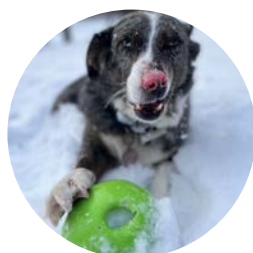
(k) Lynxy



(l) Ghost



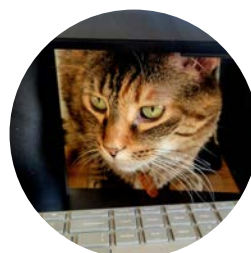
(m) Harrison



(n) Perrie



(o) Tortuga



(p) Nala



Answers: (1)k (2)bh (3)adijo (4)gn (5)l (6)m (7)e (8)c (9)f (10)p