A Newsletter Dealing with Obsessive Compulsive Disorder

NEVER say NEVER

In the midst of the seemingly endless storm, look to the promise of the rainbow - the rain shall not prevail!

Winter 2006

OCD Challenges and Solutions Seminar coming May 20, 2006

Obsessive Compulsive Spectrum Disorders, though still often misunderstood, are now thought to be genetically determined disorders aggravated by immune, hormonal and life stress events. While research into these fascinating mind/body disorders has made great advances, treatment innovations have lagged far behind. Many OC patients go undiagnosed. Even those patients fortunate enough to receive attention find there are few practitioners with the expertise to provide high quality treatment or understand the subtle effects the disorder has on the individual's lifestyle, learning abilities, relationships, career choices and even spirituality.

On Saturday, May 20, 2006, OCDFM Advisor and internationally recognized expert Dr. Christian R. Komor, and his associates Christie L. Nutkins, Ph.D., and Stephanie H. Silverman, M.A., will address these issues in a powerful, one-day seminar designed to be helpful to patients and their family members as well as treating professionals. This comprehensive program will teach steps and principles for doing self-directed behavior therapy for OCD for adults and kids, and also present modules on the common Spectrum Disorders such as trich, BDD, hypochondriasis, social phobia, hoarding, and Tourette's. So **SAVE THE DATE**, and plan on attending this event. For more information, please call the OCDFM at 313-438-3293, or visit our website at www.ocdmich.org.

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A LOT OF READING . . .

That's what you'll find in this issue of ***Never Say Never***. We have two major articles for you, both rather lengthy, but well worth the read. First, we have "Why Am I Not Getting Better" a comprehensive overview by Laurie Krauth of Dr. Fred Penzel's presentation at the OCF Conference last July. And second, you'll be able to get a head start on the upcoming "Challenges and Solutions Seminar" with Dr. Christian Komor's "The Five & Five: Steps to Fighting OCD."

THE OCD FOUNDATION OF MICHIGAN

P.O. Box 510412
Livonia, MI 48151-6412

Telephone (voice mail): (313) 438-3293
Fax: (734) 522-1404

E-mail: OCDmich@aol.com

Web: www.ocdmich.org *

* Thanks to Mark Fromm, president of Downriver Marketing LLC, for hosting our website.

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NEVER say NEVER

is the quarterly newsletter of the OCD FOUNDATION OF MICHIGAN,
a non-profit organization.

Please note that the information in this newsletter is not intended to provide treatment for OCD or its associated spectrum disorders. Appropriate treatment and advice should be obtained directly from a qualified and experienced doctor and/or mental health professional. The opinions expressed are those of the individual authors.

To submit articles or letters, write or e-mail the OCDFM at the above addresses.

LIST OF SELF-HELP GROUPS

ANN ARBOR:

2nd Wednesday, 6:30-8:30 PM
Washtenaw County Community
Mental Health
Call Mary Jo at (734) 761-9167

DEARBORN:

1st Thursday, 7-9 PM
First United Methodist Church
Garrison and Mason Streets
Call (313) 438-3293

FARMINGTON HILLS:

1st and 3rd Sundays, 1-4 PM
Trichotillomania Support Group
Botsford Hospital
Administration & Education Center,
Classroom C
28050 Grand River Ave. (North of 8 Mile)
Call Bobbie at (734) 522-8907

FLINT:

GROUP DISCONTINUED

GRAND RAPIDS:

Weekly on Wednesdays, 7-9 PM
Mixed Group: All Anxiety Disorders
Old Firehouse #6
312 Grandville SE
Call the Anxiety Resource Center
(616) 356-1614

NOTE: Starting in May, meetings will be on the 2nd Thursday of the month.

GRAND RAPIDS:

2nd and 4th Tuesdays, 7-9 PM
OCD and OCD Spectrum Disorders
Old Firehouse #6
312 Grandville SE
Call the Anxiety Resource Center
(616) 356-1614

HOLLAND:

For information, call:
Geraldine at (616) 335-3503 or
Tony at (616) 396-5089

LANSING:

1st and 3rd Thursdays, 7:00-9:00 PM
Delta Presbyterian Church
6100 W. Michigan
Call Jon at (517) 485-6653

ROYAL OAK:

1st and 3rd Tuesdays, 7-9 PM
St. John's Episcopal Church
115 S. Woodward at 11 Mile
Call Cyndi at (248)-541-0782

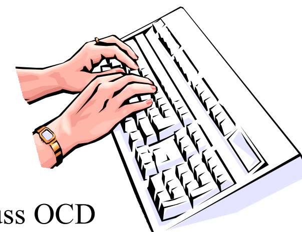
SPRING LAKE / MUSKEGON / GRAND HAVEN:

1st and 3rd Mondays, 7-9 PM
Spring Lake Wesleyan Church
Classroom E-111
Call Pam at (231) 744-3585

CLEVELAND, OHIO:

2nd and 4th Thursdays
Call Mary Ann at (440) 442-1739

ONLINE SUPPORT



OCD-Support (http://health.groups.yahoo.com/group/OCD-Support)
This is a very large and well-connected support group. Among its many members are doctors and treatment professionals who respond to questions.

OCD-Family (http://groups.yahoo.com/group/OCD-Family)
This is a mailing list for the loved ones of OCD sufferers, a safe place to discuss OCD and the way it affects the family as well as the sufferer. Its purpose is to help learn new ways of dealing with OCD from a second-hand perspective and to learn how to help our loved ones. It is asked that OCDers themselves not subscribe to this list.

Organized Chaos (http://www.ocfoundation.org/1000)
For teenagers/young adults only, this is a site for learning about OCD from each other, and from treatment providers.

Get Ready for Camp Redwing

Here it is Winter - or trying to be Winter. Temperatures have been unseasonably mild, the trees are budding, and we've had more rain and less snow. Perhaps it's a little early to get spring fever, but this weather makes it a little easier to think ahead to August. August 4, 5, and 6 to be exact. That's the weekend of Camp Redwing, our OCD Camp for kids ages 7-15. Held at the beautiful Howell Conference and Nature Center, it gives the kids the opportunity to meet others like themselves, to have fun swimming, hiking, canoeing, relaxing around a late night campfire, and snacking on s'mores. They can participate in challenge activities, and see the wildlife exhibits and programs offered by Howell. And they have a chance to meet with an OCD expert who talks to them about their experience with OCD, and who explores with them some options and ideas for Exposure and Response Prevention.

Here's what some of the kids said after last year's camp:

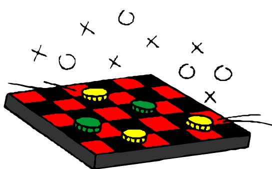
"I had a wonderful time. I was happy to know that other kids had OCD."

"Overall, Camp Redwing was a memorable experience."

"This camp was excellent!"

So plan now to have your kid(s) join us for Camp Redwing 2006. Flyers will be coming out soon. For more information, call 313-438-3293 or visit us online at www.ocdmich.org.

WORDS OF WISDOM



"Life is like a game of checkers:
You can only take one step at a time,
You can only go forward,
And you sometimes have to make a sacrifice to get to a better place."

"Your goals, minus your doubts, equal your reality."
- Ralph Marston

"Do you have the patience to wait until your mud settles and the water is clear? Can you remain unmoving until the right action arises by itself?"
- Lao-Tsu

"Be the change you want to see in the world."
- Gandhi

WHY AM I NOT GETTING BETTER?

By Laurie Krauth, MA

Fred Penzel, PhD, successfully treated an 89-year-old woman whose OCD began when Calvin Coolidge was president. (She was 6). Like many of his patients, she could have been helped many years earlier, but she went without proper diagnosis and treatment for most of her life.

"There are many reasons why people appear to fail to recover, even after seeing four or five therapists," Dr. Penzel told his audience at the 12th Annual OCF Conference. He identified nine reasons why people fail -- but shouldn't.

Dr. Penzel, director of the Western Suffolk Psychological Services, in Huntington, New York, spoke to the conference audience in San Diego July 31, 2005. He is on the OCF Scientific Board of Directors and has written widely on OCD. His books include *Obsessive-Compulsive Disorders: A Complete Guide to Getting Well and Staying Well (2000)* and *The Hair-Pulling Problem: A Complete Guide to Trichotillomania (2003).*

These are nine common reasons he gives for OCD sufferers' poor progress in overcoming their symptoms:

Fred Penzel, PhD, an OCD specialist, lists these nine obstacles to getting better:

1. **Misdiagnosis**
2. **Active Mood Disorder**
3. **Wrong Treatment**
4. **Non-Comprehensive Treatment**
5. **Weak & Ineffective Treatment**
6. **Lack of Acceptance of OCD**
7. **Low Frustration Tolerance**
8. **Sabotage by Others**
9. **Comfort in OCD's Discomfort**

1. THEY WERE MISDIAGNOSED

Some people are diagnosed with OCD when they have another mental illness with similar symptoms. Others are told they have another disorder when they really have OCD. Many therapists lack the training and supervision to properly diagnose OCD, he said. They fail to tease out the details that confirm or rule out the diagnosis. They may fail to distinguish how similar symptoms more accurately fit another disorder.

The proper diagnosis is essential to tailoring the right psychological and medical treatment to each person. To complicate matters, people with OCD may also have other disorders as well. So therapists may need to make more than one diagnosis to develop a treatment plan addressing all of a patient's problems.

Clinicians ultimately must determine if a patient meets the criteria for a disorder as delineated in the DSM-IV, the American Psychiatric Association's diagnostic manual. The DSM describes OCD as recurrent obsessions ("persistent ideas, thoughts, impulses or images that are experienced as intrusive and inappropriate") and compulsions ("repetitive behaviors--e.g., hand washing, ordering, checking--or mental acts--e.g., praying, counting, repeating words silently--the goal of which is to

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prevent or reduce anxiety or distress, not to provide pleasure or gratification."). OCD causes marked distress or significant impairment--or both.

For those who may have been misdiagnosed with OCD, he said, some of the disorders with similar symptoms that might fit them better include:

- *Autistic Disorder*. The DSM-IV's criteria includes "qualitative impairment[s] in social interaction…and communication…and restricted repetitive and stereotyped patterns of behavior, interests, and activities."

According to Dr. Penzel, "Features of this developmental disorder that are often mistaken for OCD include repetitive gestures or motions; lining up or organizing things in exact ways, saying things repetitively (such as words, phrases and sounds); and adhering to rigid schedules or ways of doing particular things that cannot be altered in any way."

Parents may notice their children doing things repetitively but for a reason other than OCD. "Autism is a disorder of language and social relatedness, not of doubt and guilt. Autistics do things repetitively for sensory reasons, or to calm their nervous systems: they are stuck in loops of behavior intended to soothe themselves but they are not experiencing guilt and doubt the way people with OCD do," he said.

Autistic people like sameness and order because it is reassuring and comforting, not for superstitious or perfectionistic reasons as OCD sufferers do, he added.

- *Asperger's Disorder*. Included in the DSM criteria for Asperger's are significant problems with functioning due to a "qualitative impairment in social interaction…, restricted repetitive and stereotyped patterns of behavior, interests and activities…, [but no significant] delays in language…or cognitive development."

Asperger's is similar to Autism but less dramatic in its presentation, said Dr. Penzel. It is a disorder of social relatedness: people with Asperger's may often be the odd-person out, said Dr. Penzel.

Features of Asperger's mistaken for OCD include "a focus on very specific, limited, and intense interests, which people with Asperger's often pursue to the exclusion of everything else, occupying many hours per day." They may lecture repetitively on favorite topics, he said, or "adhere to rigid schedules or ways of doing particular things that cannot be altered in any way." Unlike with OCD, people with Asperger's are motivated by pleasure, not anxiety, to spend excessive time on activities such as video games, math problems, on-line searches, and reading of numerous books on a subject of interest.

- *Tourette's and other Tic Disorders*. According to the diagnostic manual, a tic is "a sudden, rapid, recurrent, nonrhythmic, stereotyped motor movement or vocalization." Tourettes's Disorder involves both multiple motor and vocal tics, though not necessarily at the same time. The tics occur many times a day, and cause marked distress or impaired functioning.

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THE FIVE & FIVE: STEPS TO FIGHTING OCD

By Christian R. Komor, Psy.D.
OCD Recovery Centers of America

Obsessive Compulsive (OC) Disorders including OCD, Asperger's Disorder, Tourette's Disorder, Hypochondriasis, Compulsive Hoarding, Trichotillomania, and Body Dysmorphic Disorder are chronic and often debilitating neuropsychological problems. OCD itself is genetically hard-wired in the brain (specifically the cortical-thalamic-striatal pathway of the basal ganglia) and can be affected by personality factors, immune system changes and hormonal fluctuations. For most patients a variety of practices and procedures are needed in order to reduce intrusive obsessive thinking and compulsive behavior, heal depression and restore self-care, relationship and other life skills. Such a broad-based program is outlined in our *Obsessive Compulsive Disorders: A Comprehensive Program for Recovery* (2001) that provides different areas of treatment for obsessive compulsive disorders.

While a broad-based recovery program is essential, the core of OCD recovery remains Exposure and Response Prevention (ERP), usually conducted in the form of Cognitive Behavioral Therapy (CBT). In ERP the individual comes into *contact* with the thought, situation, person, or object they fear and remains in contact with the *feared stimulus* long enough for the brain to *habituate* to the stimulus. This is much like jumping in a cold lake of water and staying in the water long enough to become accustomed to it. Without taking the risk of exposure to feared situations it is impossible to really progress in the healing process. By doing so, on the other hand, brain imagery studies have shown us we are actually *healing* the cortical-thalamic-striatal region of the brain – something that is impossible to do through any other method - including medication.

Success with ERP-based treatment is dependent on the following ***Five Principles*** (which are then reflected in the ***Five & Five Steps***, the focus of this article): (1) *Safety* – choosing exercises that, while they may seem so, will not bring actual harm to the person, (2) *Intensity* - keeping anxiety levels between the levels of 25-75 on a scale of 0-100, (3) *Neutralization* – refusing to "undo" the exposure with *rituals* or *compulsions*. (4) *Saturation* and (5) *Duration* – finding creative way of ensuring the feared stimulus is encountered on a *regular basis* for *long enough* to cause healing in the brain (which could be measured via a SPECT scan). These are referred to as the *Five Principles* of ERP. We use these *Five Principles* like a recipe to design ERP exercises. When we include all five factors the exercise is almost guaranteed success!

But once we have designed an exercise using the *Five Principles* how do we get ourselves through the simple and yet terrifying act of turning to face fearful obsessions and remaining with them while not ritualizing. Frequently OCD sufferers will report that car accidents, public speaking, near plane-crashes and the like are not nearly as frightening as confronting an obsession! It is precisely because it is so difficult to refuse to perform obsessive-compulsive rituals in the face of the feared obsession that it is important to have a set procedure for doing so. *OCD Recovery Centers of America* has developed a specific "*Five & Five" Step procedure* for walking through the fear of Exposure and Response Prevention. These Five & Five Steps, if followed closely, will take the OC sufferer step-by-step through the flames of anxiety that can seem so intense.

These *Five Principles* of behavior therapy with OCD form the basis for the *Five & Five Steps* which we will now discuss. Note that steps 1-5 are essential to the process, Steps 5-10 are employed *only when the person is unable to resist* the urge to neutralize the anxiety (via a ritual or compulsion) or to lend additional support to the exercise. Some of the additional steps should be used sparingly and with caution because they can become rituals in themselves and therefore develop into secondary problems.

It is recommended that, after making whatever modifications are needed to tailor the procedure to one's own situation, the Five & Five Steps should be applied consistently day after day so that they become second nature. The steps have been given short labels to make them easier to remember in practice.

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1) INTENSITY	6) RENAME
2) RESIST	7) TRUST
3) CONTINUE	8) TITRATE
4) ANXIETY	9) LISTEN
5) PERSIST	10) TAKE NOTES

STEP ONE: (CHECK THE) INTENSITY

- **Only rituals achieving a rating of 25-75 are selected for ERP.**
- **Danger in selecting items with Subjective Units of Distress (SUDs) rating over 75 are: *Panic, refusal, neutralization, reinforcement of obsession.***
- **If intensity too high, try not to neutralize and**
  - **Ride out the anxiety.**
  - **Add or subtract mediator (gloves, mask, reassurance, etc.)**

Most OC sufferers have a variety of compulsive behaviors they perform on a daily basis. Some, if stopped, would result in very intense anxiety leading to panic, and an increase in future compulsive rituals. Others carry with them only mild anxiety and can be fairly easily eliminated without undue stress. In choosing which OC rituals to confront it is wise to make a list of all rituals and then rate them from highest ("100") to lowest ("0") in terms of the anxiety that would be generated if the behavior were stopped. Then rituals achieving a rating of 25-75 are selected for ERP.

STEP TWO: RESIST (THE URGE TO NEUTRALIZE)

- **A ritual is selected for elimination**
- **Individual refuses to perform the ritual behavior or thought in spite of the urgings of the OC disorder.**
- **Done with an awareness that the surge of anxiety experienced when refusing a ritual will dissipate within minutes to hours (often in 15 to 20 minutes).**

This is the most important step in the process. People with OCD will have primary and backup rituals for relieving anxiety. They can wait for long periods of time before performing a compulsion so that they can fool themselves into believing it is not connected to the initial stimulus exposure. Neutralizing strategies can be very, very subtle such as a blink, a head shake or thinking about a color. It is *essential* to realize what neutralizing strategies are being employed and to stop them. Neutralizing strategies will always short-circuit the treatment process if allowed to continue. It is better to choose an exercise that fosters less anxiety and is manageable without performing a compulsion than choose a more difficult ERP exercise and later give in and neutralize the anxiety.

STEP THREE: CONTINUE (WITH LIFE)

- **Not necessary to obsessively focus on the anxiety that is naturally generated.**
- **Simply be aware of the anxiety.**
- **Do something else – go on with life as it were - *carrying the anxiety along.***

It is not necessary to obsessively focus on the anxiety that is naturally generated when refusing to perform a compulsive ritual. The key in Step Three is to be aware of the anxiety, to see it for what it is and then do something else – go on with life as it were *carrying the anxiety with you*. The optimal procedure is to say to one self "Yes, I am anxious because of the ritual I am refusing to perform. Now I am going to go on and do something that I *choose* to do." There is an exciting element of risk here. It can be unsettling to step out and

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assert one's own choices and desires after being a slave so long to the compulsive behavior.

STEP FOUR: (FEEL THE) ANXIETY

- **Simply allow the anxiety to be present like energy passing through the body.**
- **Do "anxiety checks" every 5 minutes.**
- **Observing the anxiety level decreasing provides strong encouragement.**

Once a ritual is selected for elimination and the individual refuses to perform the ritual behavior or thought in spite of the urgings of the OCD, a surge of anxiety will be experienced. This anxiety surge will eventually dissipate within minutes to hours (often in 15 to 20 minutes). The OC sufferer is encouraged to *maintain awareness* of the anxiety by doing "*anxiety checks*" every five minutes until the anxiety has dropped by 50% from its initial **strength**. At that point the individual can go on about their daily activities without needing to maintain awareness of the anxiety. It is important to remember that anxiety may show itself in thoughts, feelings, physical reactions and, or behavior. Each individual will be unique in their pattern of anxiety reactions and it may help to identify one's specific anxiety symptoms prior to engaging in ERP.

STEP FIVE: PERSIST (50% Rule)

- **Persist in refusing the ritual until the anxiety dissipates – however long this may take.**
- **Once the anxiety does begin to reduce it is essential to avoid the temptation to perform another ritual to "un-do" the exposure.**

It is necessary to persist in refusing the ritual until the anxiety dissipates – however long this may take. Like aerobic exercise, which must be done for a certain length of time in order to have cardiovascular benefits, one's anxiety level *must* have decreased by at least 50% before any positive benefits will accrue. Of course, once the anxiety has dissipated the individual will feel no need to perform the compulsive behavior! Time is a key factor in the healing process. Many people with OC disorders will refuse a ritual, but then go ahead and do it in a little while. This will only provide the OC disorder with what is known as "intermittent reinforcement" – a strong reinforcer to continue generating obsessive and compulsive demands. It helps greatly for the patient to take note of their anxiety level (0-100) every ten minutes or so along the way. Observing the anxiety level decreasing provides strong encouragement.

<u>OPTIONAL STEPS</u>

STEP SIX: RENAME (OPTIONAL MEDIATOR)

- **The urge to perform the obsessive ritual is in reality a faulty brain message not a real danger.**
- ***Stopping all activity* and concentrating one's awareness on what's happening - on the obsession or ritual - long enough to *truly and clearly see and feel* it is just OCD and not a "real" danger or issue.**
- **Slogans and other forms of self-talk can be used to achieve this end.**
- **Have a working awareness of one's mental, physical, and emotional symptoms of anxiety. Say, "This is just anxiety caused by the obsession or compulsion I am refusing to give in to."**

In Step Six the individual then reminds him or herself that the urge to perform the obsessive ritual is in reality a faulty brain message. Usually this means actually *stopping all activity* and concentrating one's awareness on what's happening, on the obsession or ritual, long enough to *truly and clearly see and feel* it is just OCD and not a "real" danger or issue. Armed with this awareness it is then possible to be aware both mentally and experientially that the compulsion is not a real choice, but rather an expression of the obsessive compulsive disorder. Various slogans and other forms of self-talk can be used to achieve this end. It also

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helps, at this Step, to have a working awareness of one's mental, physical, and emotional symptoms of anxiety. This allows the patient to say, "This is just anxiety caused by the obsession or compulsion I am refusing to give in to." *Again, however, one must be cautious as both Steps Six and Seven can easily turn into neutralizing compulsions. They should only be used if the anxiety is so strong that it is impossible to accomplish the exercise without their assistance.*

STEP SEVEN: TRUST (OPTIONAL MEDIATOR)

- **Develop trust in a higher power, the universe, destiny or life itself to take care of the portion of reality that may be giving rise to the obsession.**
- ***Serenity Prayer* exemplifies this Step: "Grant me the serenity to accept the things I cannot change, the courage to change the things I can and the *wisdom* to know the difference."**
- **Remember that compulsive rituals are designed to try to control what cannot be controlled.**

We might think of Step Seven as the "spiritual step". Here we are developing trust which usually means trust in a higher power, the universe, destiny or life itself. The well-know "*Serenity Prayer*" exemplifies this Step: "*Grant me the serenity to accept the things I cannot change, the courage to change the things I can and the wisdom to know the difference.*" The key is in reminding oneself that compulsive rituals are designed to try to control what cannot be controlled. Yes, one may choose to brush one's teeth in order to prevent cavities, but replacing the toothbrush seven times in the toothbrush holder will not prevent AIDS. So while riding out the anxiety arising from ERP, the OC sufferer is encouraged to again and again remember to let go of what cannot and should not be controlled.

STEP EIGHT: TITRATE (OPTIONAL MEDIATOR)

- **Change choice of target.**
- **Change how target is experienced by:**
  - **Adding or removing mediators (e.g. wearing gloves).**
  - **Adding or subtracting anxiety reduction techniques.**
  - **Adding or subtracting reassurance or modeling.**
  - **Increasing or decreasing duration of exposure or physical distance.**

When creating an Exposure and Response Prevention exercise, or inadvertently encountering a exposure stimulus in daily life it is important to make the experience of the stimulus (e.g. the level of anxiety it generates) manageable. This may not always be possible, and it is preferable to face down an very high anxiety situation rather than avoid or ritualize it. If possible, however, it is always desirable to make the situation manageable in terms of anxiety (e.g. targeting a 25-75 range on a 0-100 anxiety scale). This can be accomplished by manipulating the situation in some of the various ways listed above. For example, one could spend only a few minutes but a trash can instead of an hour, or wear gloves while pumping gas, or ask someone to do the behavior first. All of these are "mediators" which will titrate the exposure to a manageable range – much as medication is titrated so that the patient will not get too much or too little. This allows us to hit the "therapeutic window" at wish the exposure does the most good without overwhelming the individual.

STEP NINE: LISTEN (OPTIONAL)

- **Confronting OCD leads the individual into a series of profound changes in perspective and emotions.**
- **Initial reaction may be increase in over-valued ideation and loss of perspective.**
- **Sadness, grief, pain and anger may follow.**

While not always the case, often after following through successfully with an ERP exercise feelings of

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grief, elation, anger, etc. will arise. It is well to give these feelings some attention, allowing oneself to vent or express them with another person, listening to expressive music, or even hitting a punching bag. The idea is not to obsess on the feelings, but simply to let the flow. Sometimes this will lead to additional realizations and insights which can then be notated in Step Five & Five. *Unlike Steps Six and Seven, Steps Eight and Five & Five will* *not* *lead to neutralization so they can be used without reservation.*

STEP TEN: OBSERVE (OPTIONAL)

- **New realizations may occur immediately following exposure to the stimulus without the protection of rituals and compulsions.**
- **Write down new awareness and realizations for future reference.**

It is generally helpful to most people with OCD to keep a journal in which they can keep track of therapeutic recommendations and homework assignments, chart progress, notate problems with procedures, and make observations. This material can be brought back to the treatment sessions and will vastly increase the effectiveness of the treatment process.

Finally, keep in mind that if one gives in to an OC ritual it is still possible to make it a "win" by clearly acknowledging that one has had a "slip" and that the OC has won but that nothing real has been accomplished. A helpful statement here would be "I gave in to the OCD and its meaningless!" instead of "I protected myself (or accomplished something) by doing the OCD compulsion." Also, if one gives in to a ritual a healthy choice would be to find another similar challenge to do right away so that the OCD doesn't feel it has had a victory.

There are, of course, many other aspects to OCD recovery - Special Characteristics such as increased needs for reassurance or symmetry, neuropsychological and physical differences, etc. OCD recovery is not simply confronting rituals and compulsions, but undertaking this courageous task leads to all kinds of positive downstream effects such as reduced depression and increased feeling of self-sufficiency and spontaneity and free-will. Without ERP other important self-help measures (e.g. learning relaxation training, aerobic exercise, taking vacations) will likely eventually be overwhelmed by the compulsions and rituals. The freedom gained through ERP is a precious gift that only a recovering OCD sufferer can appreciate fully and the self-love which develops along the way is worth the effort.

Christian R. Komor, Psy.D. is a Clinical Psychologist who combines 12 years of clinical experience treating OCD-Spectrum disorders with discoveries from his personal recovery from OCD. Dr. Komor is the author of *Obsessive Compulsive Disorders: A Comprehensive Program for Recovery* (2001), *The Obsessive Compulsive's Meditation Book* (2000), *OCD and Other Gods* (2000), and *The Power of being* (1992). Dr. Komor leads seminars nationally for professionals on optimal treatment of obsessive compulsive disorders. He is the founder of the **OCD Recovery Centers of America** based in Grand Rapids, Michigan. For more information, or to order books, tapes or materials visit www.ocdrecoverycenters.com
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Features of tic disorders that can be mistaken for OCD include repetitive motor or vocal acts, "evening up" things symmetrically, or repeating actions in order to get a "just right" sensation, said Dr. Penzel. Complex tics may involve a whole connected series of physical or verbal actions that resemble compulsions.

However, "with tics, it's like the feeling you get before you sneeze—it just feels like you have to do it." He said people are not doing it to relieve bad feelings nor as protection against harm or embarrassment but to eliminate unpleasant sensations. For people with OCD who have "just right" compulsions, it is more anxiety driven, and less of a sensatory need.

- *Obsessive Compulsive Personality Disorder.* OCPD is described in the diagnostic manual as "a pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency…"

One of Dr. Penzel's "unofficial diagnostic criteria" for OCPD is met when patients contact him because "their back is against the wall, like their job is threatened or their wife brings them in for treatment," he said. "They don't want to change. They feel these things they do are an integral part of them and give them pleasure." Often their behavior doesn't cause them distress, even if it's messing up their lives, he added. People with OCD, however, "find their symptoms unpleasant or repulsive." Further, he notices that the difference between preventing someone with OCPD and OCD from behaving in these classic ways is that the first will likely become angry and the second, anxious.

Features of Obsessive-Compulsive Personality Disorder that are frequently mistaken for OCD, he said, are an insistence on perfectionism and exactness; having rigid routines; having to be very controlling of others, and being meticulous and rule-governed; and the hoarding of useless or excessive numbers of things.

- *Schizophrenia.* According to the diagnostic manual, people with schizophrenia have "delusions; hallucinations; disorganized speech…; grossly disorganized or catatonic behavior, or negative symptoms."

Features of schizophrenia frequently mistaken for OCD include bizarre, extreme, and illogical thoughts and beliefs. People with schizophrenia believe their thoughts are true. If they have paranoid delusions, they are certain someone will be harmed. "They know it is true that, say, 'People in white cars are trying to kill me,' or 'my husband is trying to poison me.'" On the other hand, people with OCD are obsessed that someone will be harmed—by themselves or by others--but uncertain about it.

"Am I schizophrenic or do I have OCD? You can sum up OCD with two words: pathological doubt," said Dr. Penzel.

Schizophrenia has been one of the most common misdiagnoses for people with OCD due to the sometimes bizarre obsessions that can accompany OCD. Many people with OCD report family members once were hospitalized for schizophrenia who probably had OCD instead, he added.

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- *Attention Deficit/Hyperactivity Disorder.* ADD, according to the DSM, includes inattention, and with ADHD, impulsivity and hyperactivity.

Ironically, some ADHD sufferers compensate with behaviors that can look like OCD, such as extensive list-making; doing things in a certain unvarying order; repeating actions; counting while doing things; and double checking to avoid a reckless omission or error, said Dr. Penzel. A person with OCD, however, may be driven to do those things to reduce anxiety caused by obsessional thoughts that they may have made an (unlikely) error. "ADD is a disorder of attention and concentration, not of doubt and guilt as in OCD."

These are just some of the other mental health issues that resemble features of OCD. The plethora of such possible diagnoses can overwhelm someone eager to nail down the right one for them. Some end up saying, "Doc, I'm suffering from the DSM," said Dr. Penzel. The bottom line is that if you suspect you have OCD, you need to be diagnosed by someone who specializes in treating it.

2. THEY HAVE A MOOD DISORDER THAT ISN'T UNDER CONTROL

OCD sufferers may be pursuing appropriate treatment, but be waylaid by a mood disorder. If they're experiencing a major depressive episode, their mood is depressed or they have lost interest in nearly all activities. It may be a reactive depression caused or exacerbated by living with OCD, or a biological depression that persists even as your OCD improves, said Dr. Penzel.

They may be stymied by crushing fatigue, which makes even the smallest effort seem impossible. They may lack motivation due to extreme negative thinking, believing that they will be unsuccessful in treatment, that they do not deserve to recover, or that nothing can help them, he said.

At the other end of the mood spectrum, if they are having a manic episode, according to the DSM, they're experiencing "an abnormally and persistently elevated, expansive, or irritable mood," which can distort their self-esteem, need for sleep, goal-directed or pleasurable activities. They may throw their medications away and feel like they're invincible and are 'cured' without doing the necessary therapeutic work, noted Dr. Penzel.

In either case, patients need to stabilize their mood disorder with medication and therapy so they have the motivation, energy and persistence to follow through on treatment.

3. THEY'RE GETTING THE WRONG TREATMENT

Cognitive-Behavioral Therapy (CBT) and antidepressant therapy are the treatments of choice for OCD, said Dr. Penzel. He said he has not seen scientific evidence—well-conducted and reported studies that can be replicated by others--supporting other treatments, although individuals may cite success with one or more of them. Some of these alternative treatments that have been used for OCD but not extensively researched include relaxation training, biofeedback, hypnosis, diet changes, ho-

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meopathy, psychoanalysis or other non-specific talk therapy, and EMDR (eye movement desensitization reprocessing).

4. THEY'RE NOT GETTING COMPREHENSIVE TREATMENT

Comprehensive treatment involves cognitive-behavioral therapy, medication, and life balancing, said Dr. Penzel.

- Cognitive-Behavioral Therapy

Assignments involve a behavioral component—exposure and response prevention—as well as a cognitive component—"recognizing the illogical thinking of your OCD."

- Medications

Medications, specifically the SSRIs, such as Prozac and Zoloft, or the older tricyclics, such as Anafranil, can help. He said there is some scientific evidence suggesting some benefit in the B vitamin inositol, and uncontrolled evidence showing promise in the herb St. John's Wort, but he added that store products of the herb are undependable.

- Life balancing

"Health comes from a state of balance—work, school, volunteering, and helping at home; exercise; sleep; eating well, and socializing," said Dr. Penzel. People with OCD benefit from reducing the extremes of stress and excessive free time.

5. THEY'RE GETTING WEAK AND INEFFECTIVE TREATMENT

Despite a proper diagnosis and CBT treatment, people with OCD "get watered down assignments that don't sufficiently challenge sufferers' symptoms."

"I'm an industrial strength therapist," said Dr. Penzel. "You have to be to get the job done. You must experience anxiety up to the level you can tolerate and stay with the anxiety [until you habituate to it.]. Every week I want you to know you're done something better than the week before. Warm, fuzzy therapists don't challenge the patients enough."

This doesn't mean "rocking and socking people with their anxiety at a level they can't tolerate," he added, but finding assignments that are demanding enough to produce change. They also need cognitive therapy that "challenges the illogical in their own thinking."

6. THEY DON'T ACCEPT THAT THEIR OCD IS A PROBLEM

To succeed in treatment, said Dr. Penzel, "sufferers need to accept that:

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- They have OCD
- It's a chronic problem like asthma or diabetes. 'Some sufferers have a magical belief that God will take it away or they'll outgrow it'
- They will never 'perfect' their OCD
- They cannot keep on compulsively protecting themselves and others and still recover ('If I do all my compulsions just right then I won't have any anxiety')
- There are tasks they will have to accomplish on their own, in order to recover. The only way out is through, not around [the symptoms]."

7. THEY'RE SUCCUMBING TO LOW-FRUSTRATION TOLERANCE

"The *shoulds* that frequently accompany low frustration tolerance are:

- I should not have to work hard at getting the things I want—these things should come easily to me.
- I should never have setbacks, but always make continual progress.
- Getting recovered should happen very quickly.
- Treatment for my symptoms should not make me uncomfortable in any way, and above all, should not make me anxious."

Added Dr. Penzel, "It's like saying you should get surgery without getting cut or getting stitches."

8. THEY'RE BEING SABATOGED BY OTHERS

Family members and friends are profoundly affected by a loved one's OCD. They may be drawn into the sufferers' pain and rituals, make decisions for them, take over responsibilities. When the sufferers begin to get better, loved ones react in different ways—not all helpful.

Certain kinds of "help" do not help, he said:

- *Intentional sabotage*. "In one case, the sufferer's husband undermined her progress because he made all the family decisions and he liked it that way. His temper got worse and he made nasty comments."

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- *Impatience*. Family members become invested in seeing rapid progress and get too invested in each step of the therapeutic journey. With someone overcoming a contamination fear, "now you can open the door knob without a paper towel and they'll say, 'But what about all these things you *can't* do yet?'"

Dr. Penzel noted how much family members often suffer in watching and responding to loved ones with OCD. Nevertheless, he encouraged family members to step back and allow sufferers to do what they have to do on their own, even if they have occasional lapses, or even if they lose their momentum and quit altogether. Which led him to his final obstacle:

9. THEY'RE COMFORTABLE IN THEIR DISCOMFORT

"They are living with their symptoms full blast, with multiple compulsions, and everyone else has to accommodate their symptoms. Being a patient has become their full-time job," he said.

Maybe they are suffering from one or more of the other eight obstacles, such as severe depression, inadequate medication, or simply feeling demoralized by several failed treatment efforts. The bottom line is that they are not willing to get help and do the work they need to do to get better. Until they do, no one else can make them better, and Dr. Penzel encourages family members not to take responsibility for their loved ones' recovery. If the OCD sufferers live at home, he said, family members can make staying there conditional on their continued efforts to get better. Otherwise, they can live in community-supported housing until they are ready to return to doing the work to improve.

Despite those who are not ready or able to sustain the work to get better, many sufferers can and do get better, even after multiple tries.

"I don't like the terms "refractory OCD" [unremitting symptoms] or "treatment resistant," [not responsive to therapy], said Dr. Penzel. Many people given those labels could succeed under the right conditions. "The worst thing is to take hope away from you."

Success depends upon an OCD sufferers' proper diagnosis, treatment plan, and own effort. Dr. Penzel's 89-year-old patient spent most of her life living in fear of being contaminated by others. "She didn't know what it was or that anything could be done about it," said Dr. Penzel. Then one of her daughters read an article about OCD that described her elderly mother's symptoms. "Actually, it went rather quickly, once she started working on it. She was very diligent about doing her [ERP] homework," said Dr. Penzel. And her life changed.

Laurie Krauth, MA, is a psychotherapist in Ann Arbor, Michigan, treating OCD and other anxiety disorders, and is a valued member of the OCDFM Board of Advisors. She can be reached at LKrauth@comcast.net or through her website at www.LaurieKrauth.com.

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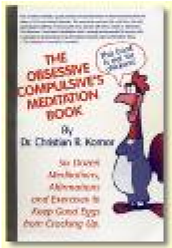

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Grand Rapids, MI: St. George Press, 2000
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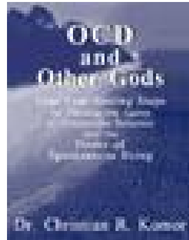

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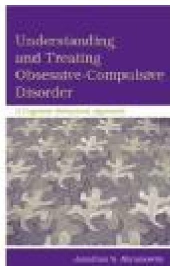

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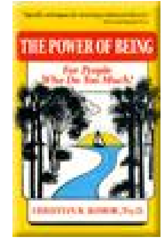

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Vol. 6, 2005, pages 2727-2740

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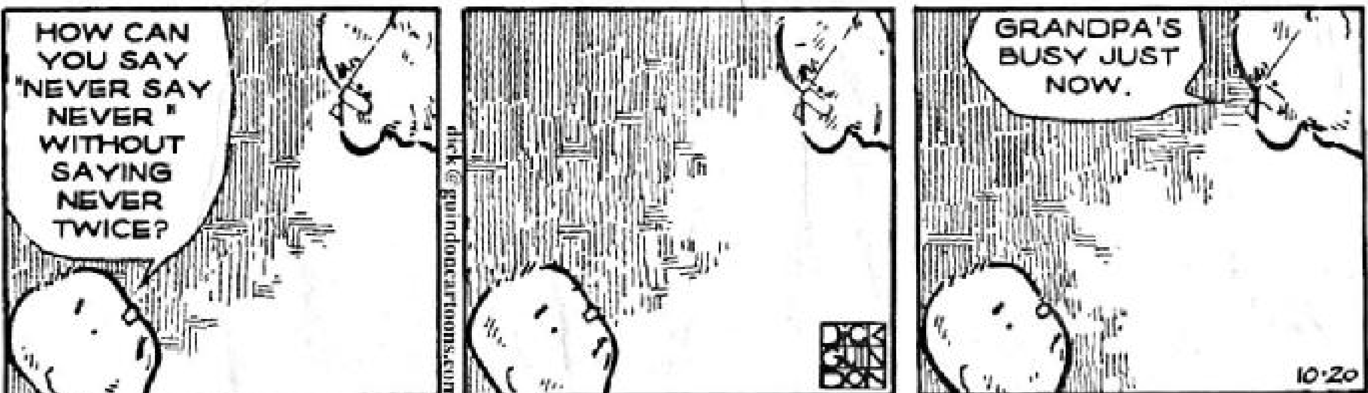

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Licensed Clinical Psychologist

Office: 28423 Orchard Lake Road Suite 216
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- To recognize that OCD is an incurable neurobiological disorder that can be treated with great results by the reduction of anxiety that OCD creates.
- To offer a network of information, support and education of parents, teachers, friends, family, and the medical community.
- To enlighten state legislators on how this disorder affects the sufferer, on entitlements under the full umbrella of the State Board of Education and the laws of the State of Michigan.

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