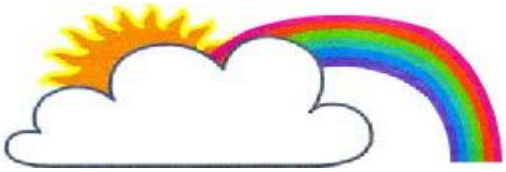
A Newsletter Dealing with Obsessive Compulsive Disorder

NEVER say NEVER



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

Winter 2012

CBT FOR OCD

As we all probably know by now, the treatment of choice for Obsessive-Compulsive Disorder is Cognitive Behavioral Therapy (CBT) in the form of Exposure/Response (or Ritual) Prevention (ERP). Perhaps we know it too well, as it has been written about and told to us *ad nauseum*. There are multitudes of books on the subject (see Suggested Reading on page 17 for a small sampling). An Internet search will bring up a myriad of references. In this issue of ***Never Say Never***, we have tried to cull through these and pick out a representative collection of articles. There's a lot of reading material here. We hope you find it helpful.

Dearborn Support Group - Thursday, April 12, 2012

Visit by Dr. Antonia Caretto, who will talk to the group about "Treating Contamination OCD." Q&A and support will follow. 7:00-9:00 pm at the First United Methodist Church, 22124 Garrison Street (at Mason). Use the side entrance (under the stairs).

Spring Program - Saturday, April 28, 2012

Dr. James Gall will be speaking on "OCD in Children and Adolescents: Family Based Strategies and Interventions." This talk is targeted to families of children with OCD. The talk will provide a concise review of pediatric OCD and its treatment, with special emphasis on the importance of family-based interventions.

Join us at 1:00 at Botsford Hospital, 28050 Grand River Ave. (North of 8 Mile) in Farmington Hills. We'll be in Classroom C in the Administration & Education Building. You can find the flyer on our website, www.ocdmich.org.

THE OCD FOUNDATION OF MICHIGAN

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NEVER say NEVER

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

LIST OF SELF-HELP GROUPS

ANN ARBOR:
1st Thursday, 7-9 PM
St. Joseph Mercy Hospital Ann Arbor
Ellen Thompson Women's Health Center
Classroom #3
5320 Elliott Drive, Ypsilanti, MI
Call Jeannie at (734) 846-9656
E-mail bellajean333@att.net

DEARBORN:
2nd Thursday, 7-9 PM
First United Methodist Church
22124 Garrison Street (at Mason)
Call (734) 466-3105

FARMINGTON HILLS:
1st and 3rd Sundays, 1-3 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 or (734) 652-8907
E-mail rslade9627@aol.com

GRAND RAPIDS:
Old Firehouse #6
312 Grandville SE
Call the Anxiety Resource Center
(616) 356-1614
www.anxietyresourcecenter.org

Anxiety (all forms)
Meets every Wednesday, 7 to 8:30 p.m.
Open to individuals who have any kind of anxiety problems as well as their friends and family members.

Adults Obsessive-Compulsive Disorders
2nd and 4th Tuesdays, 7 to 8:30 p.m.
Open to any adults who have or think they may have Obsessive-Compulsive Disorder.
Friends and family members welcome.

Body Focused Repetitive Behaviors
1st Tuesday, 7 to 8:30 p.m.
A monthly support group for adults who have Compulsive Hair Pulling, Skin Picking and Nail Biting problems.
Open to friends and family members.

Compulsive Hoarding
3rd and 5th Tuesday, 7 to 8:30 p.m.
A monthly support group for people who have trouble with compulsive hoarding.
Open to friends and family members.

Social Outings
3rd Tuesday and 4th Saturday, call for details
Challenge your anxiety in the comfort of others while attending fun-filled events.
Past activities have included: game night, visiting a bird sanctuary, concert and comedy events, sunset strolls on the beach and even canoeing.

LANSING:
3rd Monday, 7-8:30 PM
Delta Presbyterian Church
6100 W. Michigan
Call Jon at (517) 485-6653

LAPEER
2nd Wednesday, 7:30 - 9 PM
Meditation Self-Healing Center
244 Law St. (Corner of Law & Cedar Streets)
Call Mary at (810) 793-6544

PETOSKY
2nd Tuesday, 7-9 PM
Northern Michigan Regional Hospital
Community Health Education Center (CHEC)
360 Connable Avenue
Call Kevin P at (231) 838-9501
E-mail Runocd@gmail.com

ROYAL OAK:
Beaumont Hospital, Administration Building
3601 W. Thirteen Mile Rd.
Use Staff Entrance off 13 Mile Rd.
Follow John R. Poole Drive to Administration Building
Park in the South Parking Deck

OCD Support Group
1st Wednesday, 7-9 PM
Private Dining Room
Call Kevin S at (248) 991-9350
E-mail jogger112@earthlink.net

Family & Friends of Hoarders
4th Wednesday, 7-9 PM
Classroom 1, Lower Level
Call Janet at (248) 210-6012
E-mail janetkester@gmail.com
(Please note: this meeting is NOT for hoarders, but their families, friends, and supporters)

Self-Directed Treatment for OCD: The Irony of Doing the Opposite

By Paul R. Munford, Ph.D.

I remember a movie in which one of the characters went around asking people to define the word "irony." Although most of them seemed to know what it meant, they were unable to put it into words. Not until the end of the movie did one of them give the definition. I'm reminded of this because the continuation and elimination of OCD symptoms are perfect examples of irony or the occurrence of outcomes that are opposite to those that were intended. You have probably been steering clear of triggers for your obsessions and doing compulsions after contact with those you couldn't avoid. Ironically, instead of lessening your distress, what you have been doing is sustaining or even worsening your condition. To get out of this quagmire, you have to start doing the opposite of your strategy up until now. This means deliberately making contact with the triggers while refraining from doing compulsions. With enough exposure to the triggers, and for sufficient periods of time, you will notice that they become powerless to provoke distress, and the absence of distress eliminates the need for compulsions. See what I mean about OCD and irony? Exposure, ritual prevention, and awareness exercises are used to achieve this.

Exposure, Ritual Prevention, and Awareness Exercises

It is important that you understand how the exposure, ritual prevention, and awareness (ERPA) exercises are related to the way the symptoms work. So let's review the series of events that takes place during a cycle of OCD symptoms, commonly called an OCD spike. First, there's a trigger, something that is noticed in your physical, social or mental worlds. Second, it instantly activates an obsession -- thoughts, feelings or impulses that are distressful. Almost simultaneously, you feel fear, guilt, apprehension, dread, anger or any number and combination of distressing emotions. These three events -- exposure to a trigger, activation of an obsession, and feelings of distress -- are sensed as happening together, as a single event. Therefore, the terms, "trigger," "obsession," and "distress" are used interchangeably to refer to this seemingly single event -- the spike. Your natural reaction is to turn it off as quickly as possible. Finally, by trial and error, you find out that by repeating certain actions and/or mental gyrations you get temporary relief until the next obsession hits.

ERPA exercises address each one of these events. First, you select a trigger for a particular obsession-compulsion combination and then practice exposure to this trigger. During the exposure, the next step is to refrain from rituals and instead practice awareness of the distress. When this is successfully done the distress fades away. Because the obsessions that used to cause terrible anxiety no longer has that power, it becomes insignificant, making it intrusive and repetitive no more. With the absence of the obsessions, there is no need for compulsions. The exercises have changed the brain, which in turn changes behaviors and emotions. Desensitization has occurred. The exposure exercise is the vehicle, the Rolls Royce of treatments, which delivers this result.

By practicing the exercises at least one to two hours per day (including weekends and holidays), you should made good progress. When this schedule is adhered to, most people desensitize themselves to the particular trigger they're working on within five to seven days. This success gives them a big dose of confidence that they can control their anxiety, and increases their motivation to pursue and eradicate it. They now truly believe they will become "scared fearless."

To put together an exposure exercise, you'll be following these steps:

1. Select a trigger, an obsession-compulsion combination for elimination.
2. Practice exposure: by bringing on the obsession in reality and in imagination.
3. Practice ritual prevention by refraining from doing compulsions and fear blocking behaviors.
4. Practice acceptance fully experiencing the triggered thoughts, images, impulses, emotions and physical sensations they set off.

I'll explain each of the above activities as follows:

(Continued on page 9)

ERP Therapy – An Analogy

By Janet Singer
From her blog "OCD Talk", ocdtalk.wordpress.com

One of the reasons I became an advocate for OCD awareness was to spread the word that Exposure Response Prevention (ERP) Therapy is the therapy of choice for treating Obsessive Compulsive Disorder. Unfortunately, I sometimes come across first-person blogs where OCD sufferers equate this therapy with torture, and therefore refuse to try it. Others feel it may be helpful but are just too afraid to attempt it.

On his blog, Dr. Steven Seay compares ERP Therapy to an exercise program, and using this analogy, really sets the record straight as to what this therapy involves when dealing with a competent therapist:

I often think about ERP as an exercise program for your brain. Why do people exercise? Typically to improve their quality of life in some way — be it related to health, aesthetics, or the way it makes them feel. People don't take up exercising for no reason at all–it's always purpose-driven. This is just like ERP. Why would you do it? Because it's going to enhance your life in some way.

The analogy can be taken a bit further, though.

Exercise is not a singular activity. It's something that's often based around targeting a particular muscle group or certain aspect of health. People who want big biceps do different exercises than people who want to lose weight. This is similar to ERP. People who want to be less bothered by unwanted thoughts (e.g., thoughts of hitting someone with your car) do different exposures than someone who is afraid of contracting a deadly disease. The form of the "exercise" reflects a specific therapeutic goal.

Moreover, there are multiple ways to target the same muscle group. People who want to work on their abs might consider crunches, leg lifts, push-ups, etc. In ERP, there is no one exposure that will help you get better. Instead, there is an array of options that might work for you.

There's also the hierarchical nature of exercise. If you want to get stronger, it's smart to start with light weights and build up to heavier weights. It would be downright dangerous to attempt a 500lb bench press without proper training. In ERP, going for that "10" on your hierarchy is ill-advised at the beginning of treatment. Before going there, you need to lay the proper groundwork first. A gradual approach might take more time, but it will get you to the destination without subjecting you to unnecessary injuries.

Finally, the world is full of different types of trainers. Not everyone is a drill sergeant. The best trainers will listen to you, work with you, and try to understand where you're coming from. They'll then use their expertise to design an individualized plan for you that is based on your goals, preferences, and perspective. The best therapists I know follow this same approach to treatment.

My position is that if you're completing an exposure under duress, you're unlikely to benefit from it. It's the process of choosing to face your fear (and willingly embracing the uncertainty that comes with it) that really makes the difference.

Thank you, Dr. Seay. Here's hoping your words inspire all OCD sufferers to "hit the gym!"

One Therapist's View: Roxie's ERP Session

by Stephen Martin, M.F.T. and Victoria Costello with Linda L. Simmons, Psy.D.

What follows is a simulated account of an ERP exposure session for a fictional fourteen-year-old client named Roxie. Roxie is a girl who suffered from untreated OCD for approximately five years before beginning CBT therapy. Although simulated, Roxie's story is entirely authentic. It's based on several clients who faced and defeated exactly the same level of fear and paralysis as the fictional Roxie.

Whenever Roxie came to a closed door, she had to bow down in front of it, and then pry it open with her foot or elbow. Her contamination fear dictated that she could never touch the doorknob with her hands. Roxie had been opening doors this way for as long as she could remember, so long that no one at home even noticed anymore. But now Roxie was getting embarrassed at school when she had to go through a closed door. She wanted her rituals to stop.

In order to make them stop, I told Roxie she would have to tell me in therapy exactly what would happen if she opened a door and didn't use her rituals — the bowing down and using elbows and feet and whatever else she used to stave off the disaster she feared.

When I asked Roxie whether she'd rather go through the rest of her life using feet and elbows to open doors, she got visibly upset and began to cry. I asked her again to say what would happen if she touched the doorknob with her hand, and she reluctantly agreed.

With tears falling down her face, Roxie began to describe her worst fear: how she'd come to the door to the gymnasium at school, and as soon as she touched it with her fingers, invisible germs would jump onto her from the doorknob, then these “creepy crawlies” as she called them would crawl up her arm, and infect her with AIDS. She then described a picture of herself lying in a hospital bed, her body emaciated and covered with sores. In this, her worst-case scenario, Roxie's AIDS would quickly lead to her death, and her mom and dad would be sorry they'd ever made her go to school. Roxie's visualization ended with her tearful parents standing at their daughter's funeral casket. After she finished describing this scene, Roxie was exhausted, breathless, and perspiring.

After she'd recovered her breath, I congratulated Roxie for getting through this part of the exposure and asked her to notice the fact that she was quite alive and well. I then asked her if she was up to the task of performing the same visualization at least three times a day, every day, until our next session. She begrudgingly agreed.

Roxie returned the following week and reported her success at performing this exposure exercise for each of the seven days since I'd last seen her. I congratulated her again and then asked if she felt ready to do the very thing she feared — touching a real doorknob. Most difficult of all, Roxie would open an actual doorknob without using any of her usual rituals, no bowing down, no using feet and elbows, no counting, no prayers — nothing but her bare hands.

Roxie started at home, opening the front door, the door to the bathroom, and the door to her own room without using rituals. Her mom helped her keep a chart of her progress. But the real test came at school, where Roxie, on her own, finally got to the point where she could open the gymnasium door without using any of her old rituals. It was a major achievement.

Now Roxie can open doors at school and anywhere else she needs to. Not that it's always easy, she says. But if she gets into trouble again, Roxie knows what to do. She can go back to her exercises, picture her worst fear until the anxiety subsides, and then open a door the way everyone else does.

This article was found at:
www.netplaces.com/parenting-kids-with-ocd/deciding-on-treatment-cbt/one-therapists-view-roxies-erp-session.htm

GETTING THE RIGHT TREATMENT FOR AN OBSESSIVE-COMPULSIVE DISORDER

By Fred Penzel, Ph.D.

Whenever you get the name of a behavioral therapist or psychiatrist, whatever the source, be sure to check out the practitioner's credentials and level of knowledge and experience. Don't be afraid to conduct a mini-interview with them when you call. You have the right to assertively question their ability to help you. Be sure to ask the following types of questions when you call the practitioner:

1. "What degrees do you hold and are you state licensed?" (Avoid the unlicensed as they are unregulated, uninsured, and you will have no protection if you feel you have not been treated properly.)

2. "Do you specialize in OCD (or Body Dysmorphic Disorder, Trichotillomania, Compulsive Skin Picking, or Compulsive Nail Biting as the case may be)? What are your qualifications, and have you had any special supervised training in the treatment of my disorder?"

3. "How long have you been in practice? How many cases of my disorder have you treated? What percentage of your cases have been adults vs. children. How many cases of this are you currently treating?"

4. "What is your orientation?" (Ask this question only if you are calling about getting therapy, not medication. The correct answer should be 'behavioral' or 'cognitive/behavioral.')

5. "Do you endorse the use of behavioral therapy together with medication?" (Ask this if you are calling a psychiatrist. The correct answer should be "Yes.")

6. "Do you endorse the use of medication (if necessary) together with behavioral therapy? (Ask this if you are calling a behavioral therapist. The correct answer should be "Yes.")

7. What techniques do you use to treat disorders such as mine? (Ask this if you are calling about cognitive/behavioon for OCD and BDD, and Habit Reversal Training as well as Comprehensive Behavioral Therapy for TTM, skin picking and nail biting. (A therapist who uses these techniques is probably trained in cognitive therapy as well, but ask if they have training in this approach anyway.)

8. What is your fee? Are your services covered by insurance (if this is an important factor in affording therapy)? Note: Check your own insurance coverage before you call to make sure you are covered for outpatient mental health services. Also find out about how much coverage you have.

9. How often would you have to see me? (Once per week is about average, unless you are looking into intensive short-term therapy for OCD or BDD).

10. On the average, how long does the treatment take? (This may be a difficult question to answer if there are other problems to be solved in addition to an OC disorder)

If you are not happy about the answers you are getting, or if the person you are talking to is being evasive, don't hesitate to go elsewhere. Keep trying until you find someone you feel comfortable with. In any case, be persistent and don't give up.

Fred Penzel, Ph.D. is a licensed psychologist who has specialized in the treatment of OCD and related disorders since 1982. He is the executive director of Western Suffolk Psychological Services in Huntington, Long Island, New York, a private treatment group specializing in OCD and O-C related problems, and is a founding member of the OCF Science Advisory Board. He can be reached at penzel85@yahoo.com or through the phone number on his website, www.wsps.info. Dr. Penzel is the author of "Obsessive-Compulsive Disorders: A Complete Guide To Getting Well And Staying Well," a self-help book covering OCD and other O-C spectrum disorders.

Top Mistakes Made by Therapists Treating OCD

Common causes for OCD treatment failure

by M. Williams, Ph.D.

Most people seeking mental health treatment are unaware of the wide variety of perspectives and theoretical orientations that factor into the treatment process. Not every therapist who claims to treat OCD actually knows how to do it. OCD treatment is a type of cognitive behavioral therapy (CBT) that requires a specialized protocol called Exposure and Ritual Prevention (ERP or EX/RP). For example, although any medical doctor can take your blood pressure, only a few can do heart surgery. Likewise, just about any therapist can help someone who is feeling a little blue, but only a few can effectively treat OCD.

But **how can you tell the good therapists from the bad ones?** The following guidelines are the most common mistakes made by therapists in the treatment of OCD. If your therapist is making any of these mistakes, you may consider finding someone with more experience and better training.

Providing Reassurance

People with OCD often feel the need to be constantly reassured in regards to things that make them anxious. Most therapists have been trained to provide reassurance to clients as needed, and certainly a small amount of reassurance is appropriate at times. However, compulsive demands for reassurance are an OCD ritual that must be stopped if the client is to make progress. The therapist should explain to the client that requests for reassurance will not be heeded. Furthermore, friends and family should not be used as a source of reassurance by the client. Inexperienced therapists may unwittingly spend whole sessions providing reassurance to their OCD clients. Therapists must teach their clients that **reassurance-seeking should be avoided** at all costs.

Identify the Core Fear

Most people with OCD have many different compulsions, and for treatment to be effective, the person with OCD must learn how to stop their compulsions. Each compulsion can be individually addressed in the treatment process. However, it is very important to determine what the person with OCD is most afraid of, because chances are all of the compulsions spring out of a single core fear. If a therapist addresses the compulsion without getting to the core fear, it is just like cutting the top off of a weed. A new compulsion will spring up, leaving the core fear (and the OCD) intact.

Exploring the Roots

Searching for the core fear should not be confused with digging for the "root" of the problem. People with OCD often believe that their disorder was triggered by a particular event. They may believe if they can just figure out what caused it, then maybe they can fix it. However, OCD is caused by a combination of genetics, environment, and stressors. So there is no cure to be found be ruminating about the origins of the disorder. Unfortunately these types of musings fall very neatly in line with a type of therapy called psychoanalysis or psychodynamic therapy, also called "talk therapy." This treatment includes understanding a person's childhood as a way to indirectly cure emotional problems. This approach simply **does not work** for OCD. CBT is the only proven treatment, and there are over 100 research studies that bear this out.

(Continued on page 13)

Continued from page 4

Selecting an Obsession-Compulsion Combination for Elimination

The best obsessions-compulsion combination to target is usually the obsession-compulsion combination that is the least distressful. Even though you may be eager to get rid of the most troublesome of your symptoms, it's best to start with the one that provides the greatest chance for success. After all, nothing succeeds like success. Don't worry; we will eventually deal with all of your triggers. As you are aware, there will be some stress associated with the exercises you are about to undertake. So start with the easiest one first to keep the distress at a minimum.

Exposure: Bringing on the Obsessions

The exposures involve making contact with triggers for obsessions in reality, which are in the outer, physical and social world, or in imaginary situations, which are in the inner, mental world because fear is the problem and fear is the solution. I realize that the idea of facing fear is quite scary, but it's necessary. In case after case, patients have reported that once they start confronting fear, they find it not to be nearly as distressful as anticipated. More importantly, they discover that exposure works. The obsessions stop triggering fear and become just "thoughts." Being neutral with no emotional impact, they are insignificant and gradually fade away.

Shaping

Keep in mind that the exposure exercises are done in a most gradual way, moving toward a goal slowly. This gradual way of making progress is called shaping. Start with a situation that causes only minimal distress and stay with it until you have little or no reaction to it. Only then do you take on another situation, one that's only slightly more difficult than the first one, and stick with it until the distress evaporates. This process is continued until you have been thoroughly exposed to all of your obsessions, including what you initially estimated to be the most frightening. By the time you get to it, you will have been desensitized by the exposure exercises leading up to it, so that the final step will be no more difficult than the first one. This process, moving toward a goal in small steps, is an important part of the recovery process.

For exposure to succeed in erasing the fear, there are two necessary conditions. First, rituals, and any other means of dodging the exposure, must be prevented. The use of false fear blockers will be fully discussed in the next section. For now let's discuss the second of these conditions, the need for prolonged exposure. Exposure sessions must be long enough for you to experience a noticeable decline in your distress during the exposure. This means your sessions could be for an hour or more. What people typically feel during their sessions is a gradual rise in distress, which levels off after several minutes. Then it starts to decline. It is during this phase that you‘re receiving the benefits of the exercise. Whatever the trigger, it’s losing its power to provoke fear. With the next exposure session, and subsequent ones, you'll find that the fear at the beginning is lower and falls away faster, until eventually you'll feel little or no distress. You will have neutralized the trigger, and learned that exposure alone will free you from anxiety without resorting to the use of faulty fear blockers

Keep your exposure sessions to no more than 90 minutes by selecting triggers that are in the mild to moderate range of difficulty. Exposure can be mentally and emotionally draining, so you don't want to cause an unnecessary hardship by overdoing it. If you underestimate the power of a trigger and find that it's taking more than 90 minutes for the distress to decrease, stop working on it and replace it with an easier exercise. You can return to the one you underestimated after the easier exercises have desensitized you.

As mentioned above, exposure exercises can be in reality or in imagination. Exposures in reality aim to eliminate obsessions triggered by situations in the real world, your physical and social environment. Exposure activities of this kind require being physically involved with situations that trigger obsessions. Exposures in imagination aim to eliminate obsessions triggered by thoughts and images of imaged dreaded future events that are impossible and improbable. Exposures of this kind, since they exist only in your mind's eye, require contact with the imagined triggers. One of the best ways to do exposure in imagination is by writing down the content of your obsessions and recording this scenario on audiotape and listening to it repeatedly for as long as it takes to feel some relief. You can also practice exposure to this scenario by rewriting and rereading it for extended periods of time, again, until you feel your distressed lessening.

(Continued on page 10)

Continued from page 9

For both types of exposure exercises, it is of the utmost importance that you do not stop them while your anxiety is up. If you do, desensitization is prevented and you can even be further sensitized to the situation you're trying to neutralize. With this in mind, schedule your exposure sessions at times when you have enough time to complete them, and know that you will not be interrupted, or distracted. The best results are obtained when you practice every day, including weekends and holidays. A momentum develops that makes the practice easier with faster results. I also recommend that you do the exercises early in the day. This way you're less likely to put them off and the thought of doing them is not hanging over your head like the sword of Damocles for the bulk of the day.

Ritual Prevention: Refraining from False Fear-Blocking Behavior

A false fear-blocker is any action or thought immediately following an obsession that reduces the fear. I use the term "false" because the reduced fear is only temporary and returns with the next obsession. Its greatest harm is blocking exposure, which prevents recovery. The most common false fear blockers are: physical and mental compulsions; distraction; avoidance; and reassurance seeking.

Physical and mental compulsions are voluntary actions that are under your control. Just as you can control the movement of your muscles, you can control the performance of physical rituals. The same is true for mental rituals; they are willful words that you say to yourself and images that you purposely produce. The question isn't, "Can I prevent rituals?" but, "Am I willing to prevent them?" If you wish to overcome OCD the answer must be "yes." The price you'll pay for giving them up -- short-term, mild anxiety -- is well worth the long-term benefit of freedom from OCD. The old saying, "it's easier than you think", has been found to be true by all the courageous people who have abandoned rituals and overcome their suffering. You can be one of them. Remember that by shaping your exposures you can control your anxiety level, which will make it easier to relinquish the rituals.

Distraction is probably one of the first false fear blockers people use to cope with obsessions. By trying to get their minds on something else, they hope to ignore obsessions with their attendant anxiety and distress. Really paying attention to what they're doing, constantly being busy, and keeping on the move are ways those of a more energetic bent may use to compete with repetitive, intrusive thoughts and images. Listening to music, chattering incessantly and mindlessly are resorted to by others attempting to dampen the impact of obsessions. Those with the tendencies to worry may even concentrate on troublesome problems of everyday life in efforts to push their obsessions out of mind. The most drastic and decidedly dangerous distraction is inflicting self-injury, frequently to the head, as if to drive out demons, expiate guilt, or exchange physical pain for emotional anguish. Distractions, like their fear blocker cousin, compulsions, only offer a frequently unpredictable, short term let-up from the distress of inevitably recurring obsessions. Distractions must be abandoned so that the genuine fear blocker can't work -- exposure.

Avoidance -- as you know by now -- is the opposite of exposure and prevents recovery. Prior to having this knowledge, however, you did what came naturally and stayed away from triggers that activated irrational thoughts, images and impulses. Now, you need to take the path to recovery, the one that follows the fear. If you stray from it and wander into the wasteland of avoidance, your journey will be without end. Or, as one of my patients said, "I get it. The idea is to be like a heat seeking missile, fix on the fear, follow it, and blow it up."

Avoided situations can be your ally when you recognize that they are actually triggers for your obsessions, and as such, targets for desensitization. When they have been neutralized, and you are able to easily approach them, you will have demonstrated the ultimate proof of a successful treatment outcome.

Reasoning is probably the most commonly used fear blocker even though the person realizes, most of the time that their fears are unreasonable. However, during severe OCD spikes, this understanding weakens and doubts arise that the dreaded thoughts could be real. For example, could the thoughts really mean that "I have a major character defect or that I am crazy?" Just as nature abhors a vacuum, humans abhor uncertainty. We deal with it by rationalizing, analyzing, intellectualizing, theorizing, and using all kinds of mental manipulations attempting to achieve certainty. This happens in OCD when the faulty fear blockers of reasoning, "thinking things through," and challenging irrational thoughts are called into play. As you already know, these efforts at relief are futile. We have little direct control over our emotional reactions

(Continued on page 11)

because emotions happen to us, they're not things we will to happen. Our rational control of fear is weak; but fear can easily hijack rational control, doing so routinely in OCD. This is because the connections from the brain's emotional systems to the rational systems are stronger than connections from the rational systems to the emotional systems (LeDoux, 1996). Philosophers, poets, and other sages have expressed this understanding over the centuries, and joining them today are neuroscientists reporting discoveries about how the brain works. Remember, with fear, what you think won't help you, but what you do will.

Reassurance is one of the most powerful and unrecognized of these fear and recovery blockers. It's a form of compulsion that are I've found in over 90 percent of the people I've worked with. Because so many compulsively seek reassurance to calm their OCD and anxiety, it deserves special attention.

People with OCD worry that their obsessions might come true. To ease this distress they ask other people, usually family members or close friends, over and over again to reassure them that their fears will not materialize. Because obsessions are always unrealistic, the family members or friends (and even therapists) tell them there is no need to worry; nothing bad is going to happen. For instance, it is quite common for people with fears of being irresponsible or careless to seek reassurance that they are neither. Typically they get the reassurance that they want, and temporary relief, but like other compulsions, reassurance blocks recovery. This is the first paradox. Reassurance is not helpful -- it's harmful. However, the short-term relief it provides is rewarding enough to keep the person repeatedly seeking more, which is the second paradox. The more reassurance received, the more reassurance wanted. Trying to satisfy the demand is like trying to fill a bottomless pit.

In addition to hindering recovery, incessant requests for reassurance can grow to be overbearing demands that lead to interpersonal strife. In one case, after her husband's demands became so intense and frequent, one woman actually moved out and rented an apartment of her own. Her husband entered an intensive treatment program where both were helped and the reassurance stopped. This is an example of the third paradox. Once reassurance is eliminated, the reassured finds no further desire for it accompanied by a decrease in their obsessions and other compulsions. How, then, should you handle your urges to ask for reassurance?

First. Stop asking for reassurance. Identify your most frequent questions and do not ask them. Avoid subtle, indirect ways of getting reassurance. These may be unknown to the reassurers, but knowingly practiced by you. For example, one client I worked with would abruptly stop doing whatever she was doing, sit down and space out. Her husband learned that these behaviors signaled that she was caught up in obsessions, and unbeknownst to him, they became a nonverbal request for reassurance that he would immediately provide. It was his cue to begin telling her not to worry, that her fears were irrational, that it was only her OCD. So in addition to attending to the obvious requests, subtle, indirect ones also need to be stopped.

Second. Educate your significant others about the harmful effects of reassurance. Have them read this passage. Explain that providing reassurance interferes with recovery.

Third. Create a gentle refusal statement. At first, you will most likely continue to seek reassurance despite your efforts to abstain from them. Therefore, people from whom you typically get reassurance need to work with you to create a palatable way to say no. One way of doing this is for them to say, "I think you're asking for reassurance. Remember, reassurance is not helpful; it's harmful. Therefore I'm not going to respond." However, if this doesn't work, it's possible that the agreed upon statement itself has become reassuring, or that you believe that nothing bad will happen because the reassurer would warn you. In this case, the best way to end it is for the parties to stop talking about OCD entirely.

Awareness

I guess everybody's heard that you must face your fears to overcome them. That is easy to say but hard to do. Our instinctive reaction in the face of threat is fight or flight. This reaction has survival value for dealing with true dangers, but not for the false dangers you fear with OCD. Survival for you is overcoming OCD, which requires experiencing the fear, sticking with it, immersing yourself in it, and subduing it. Reading this may stoke anticipatory fears, but keep in mind that you can control your fear levels by approaching the triggers gradually so that you feel only mild to moderate levels or

(Continued on page 12)

of anxiety. On making contact, you might notice that the fear gradually rises but then levels off, and after a while it begins to decrease. It is during this last phase that you are getting the benefits of treatment. You are being desensitized.

While facing the fear, your task is to pay attention to your uncomfortable thoughts, and emotional and physical sensations. Dwell on the scary thoughts and images. Do the opposite of what you have been doing and accept the fears as being possible. Imagine the dreaded future events happening. Say to yourself, "So be it." Concentrate on the prospect of living in a world of uncertainty, of never knowing if and when something bad is going to happen, of never getting over the anxious condition, and so forth and so on. Keep thinking about thoughts and calling up images to deliberately provoke fear. In this way you are using fear to fight fear. You can't overcome fear by trying to go around it but only by going through it. Really be aware of the emotions you are experiencing.

Also notice your body's physical reactions. Where do you feel the anxiety in your body? If your heart is beating faster and harder, tune in to it. If you have muscle tension, focus on that. If you're breathing faster and harder notice it. Are your stomach and chest tight? Do you feel hot? Are you sweating? If the answer is yes, it means that you are on the right track because you're feeling the fear and letting it burn itself out. By pursuing the fear, you are destroying it. Exposure is to obsessions and compulsions as sunlight is to vampires. All of these bad feelings are for the good. You'll know this for yourself when, after several exposures, the fear no longer exists. You won't be able to summon it even if you try.

However, you might be concerned that the obsessions will become stronger if you give up your efforts to stop blocking them or if you deliberately bring them on. Or you might worry that whatever you dread will happen. Paradoxically, neither of these outcomes occurs. Instead, the exact opposite happens; you will recover as a result of re-training your brain's fear system to stop making false alarms about harmless events. You will be desensitized to the previous fear triggers and see them as they truly are -- harmless thoughts and images that are simply part of the normal flow of your stream of consciousness. In other words, OCD is erased when the unwanted thoughts, images, and impulses are faced, and embraced.

You may ask, "If exposure to fear is all that's required to get over OCD why hasn't this already happened? I've had these obsessions for many years and they just keep coming." The answer is that you have used futile fear-blockers to cut off distress from the obsessions. This means that your exposures to the fear haven't been long enough for it to naturally drop, which it will, simply as a result of your feeling it. You will fully understand the truth of this after you've completed your first exposure exercise.

The above exercises may seem daunting. But keep in mind the benefits they offer:

- Changes in emotions from high anxiety too little or no anxiety
- Allowing rational thoughts to replace irrational ones
- Ability to maintain employment, volunteer activity, or pursue education or training goals
- Engaging in a normal interests and routines
- Enjoying satisfactory family and social activities and relationships

Good luck. You've got the power!

Paul R. Munford, Ph.D. is a clinical psychologist and director of the Cognitive Behavior Therapy Center for OCD and Anxiety. This article can be found at ocfoundation.org/print.aspx?id=625 .

Over-explaining

People with OCD often believe that the therapist must understand every facet of their experience in order to properly diagnose and treat the OCD. As a result the person with OCD may spend much time talking about childhood issues, experiences during adolescence, observations about their own thoughts processes and the world, and theories about how their OCD might be overcome. It is quite easy for a lazy therapist to sit back and let the OCD patient ramble, and then take their money at the end of the session. However, this tendency to over-explain is actually a compulsion that should not be tolerated by the therapist. A good OCD therapist will help the client understand this and gently interrupt as needed in order to move the therapy forward.

Covert Rituals

Compulsions can be overt rituals, like washing over and over, or they can be covert, such as repetition of silent prayers. Mental rituals are a type of covert compulsion that takes place completely in a person's mind. Mental rituals include things like mentally reviewing events, self-reassurance, mental undoing, mentally monitoring vital signs, checking for signs of arousal, silent counting, etc. Sometimes people with only covert compulsions believe they do not have any rituals (sometimes called "pure obsessionals" or "pure-o"). Therapists must address these covert compulsions in treatment because covert rituals maintain the disorder in just the same way as overt compulsions. Failure to address mental compulsions will result in treatment failure.

ocd types http://www.ocdtypes.com What's your type?

This article can be found at www.ocdtypes.com/ocd-therapist-errors.php

Words of Wisdom

Between stimulus and response there is a space. In that space is our power to choose our response. In our response lies our growth and our freedom.

- Viktor Frankl

You don't have to control your thoughts; you just have to stop letting them control you.

- Dan Millman

The Poisoned Parrot

Imagine you're given a parrot. This parrot is just a parrot - it doesn't have any knowledge, wisdom or insight. It's bird-brained after all. It recites things 'parrot fashion' – without any understanding or comprehension. It's a parrot.

However, this particular parrot is a poisoned and poisonous parrot. It's been specifically trained to be unhelpful to you, continuously commenting on you and your life, in a way that constantly puts you down, criticising you.

For example, the bus gets stuck in a traffic jam, and you arrive at work 5 minutes late. The parrot sits there saying: "There you go again. Late. You just can't manage to get there on time can you. So stupid. If you'd left the house and got the earlier bus you'd have arrived with loads of time to spare and the boss would be happy. But you? No way. Just can't do it. Useless. Waste of space. Absolutely pathetic!"

How long would you put up with this abuse before throwing a towel over the cage, or getting rid of the parrot?

Yet we can often put up with the thoughts from this internal bully for far too long. Decades. We hear that 'parrot', believe the 'parrot', and naturally get upset. That then affects the way we live our lives – the way be behave towards others, how we are, what we think about others, what we think about the world, and how we think and feel about ourselves.

We can learn to use the antidote: just notice that parrot, and cover the cage! "There's that parrot again. I don't have to listen to it – it's just a parrot". Then go and do something else. Put your focus of attention on something other than that parrot. This parrot is poison though, and it won't give up easily, so you'll need to keep using that antidote and be persistent in your practice!

Eventually it will get tired of the towel, tired of you not responding. You'll notice it less and less. It might just give up it's poison as your antidote overcomes it, or perhaps fly off to wherever poisoned parrots go.

Adapted from "The Malevolent Parrot" – Kristina Ivings

MARK YOUR CALENDARS FOR 2012

Dearborn Support Group Special Meeting, Thursday, April 12, 7 pm.
Visit by Dr. Antonia Caretto, who will talk to the group about "Treating Contamination OCD." Q&A and support will follow. First United Methodist Church, 22124 Garrison Street (at Mason), Dearborn, MI. (Use the side entrance, under the stairs.)

The OCD Foundation of Michigan Spring Program, April 28, 1 pm.
The speaker will be Dr. James Gall. He will discuss OCD in children with regard to family and school strategies. Botsford Hospital, Administration & Education Center, Classroom C, 28050 Grand River Ave. (north of 8 Mile), Farmington Hills, MI.

Ping Pong 4 OCD, April 21 in Petoskey, MI.
Contact Kevin Putman, (231) 838-9501, runocd@gmail.com, www.runocd.org

The Trichotillomania Learning Center Annual Conference, May 4-6
Anyone who has ever been to a TLC Conference will tell you it can be a life-changing experience. In 2012, you only have to go as far as **CHICAGO!** See their website at www.trich.org.

The International OCD Foundation Annual Conference, July 27-29
The 2012 IOCDF Conference is likewise being held in **CHICAGO**. See their website at www.ocfoundation.org.

Know a Good Therapist??

Are you working with a therapist that you like, that knows a lot about OCD and how to treat it? Have you had good success with your treatment professional?

TELL US. WE'D LIKE TO KNOW.

Call the OCD Foundation of Michigan at 734-466-3105, or e-mail us at ocdmich@aol.com.

Bulletin Board

FREE OFFER FROM OCDCHALLENGE.COM

We have received notice of a free offer that might be of interest to some of you. There is a website that offers an interactive self-help program for those dealing with OCD. The site is OCDchallenge.com, and it is particularly useful for individuals who cannot afford or do not have access to standard OCD treatment. They are currently offering 6 months free access to the site courtesy of the Peace of Mind Foundation (peaceofmind.com). When signing up, use the promo code "POMA".

If you do choose to avail yourself of this opportunity, please let us know how you like it, if you think it is effective, useful, or "do-able" for OCD sufferers. We'd like to hear from you.

Case Western Reserve University Studies

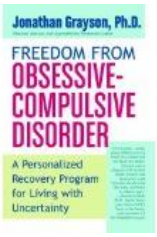
Researchers at Case Western Reserve University are conducting two online studies about the relationships of individuals with OCD or hoarding. Each study involves completing questionnaires online about relationships, emotions and OCD. You must be at least 18 to participate. Those who participate may enter into a raffle for a Target gift card. The information gathered from this study may help to improve therapies for OCD.

For more information:

Individuals with OCD and/or hoarding: **filer.case.edu/~axp335/ocd.htm**

Relatives and significant others of those with OCD and/or hoarding: **filer.case.edu/~axp335/famocd.htm**

SUGGESTED READING



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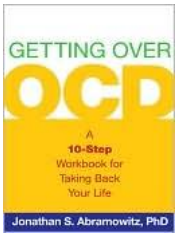

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Cherry Pedrick, RN
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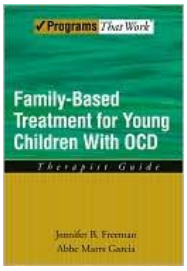

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Tracey K. Lichner
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Second Edition
Oxford University Press, 2012
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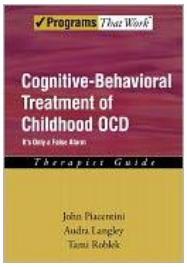

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It's Only a False Alarm: A Cognitive-Behavioral Therapy Program
Workbook
Oxford University Press, 2007
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3/2012

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You've finished reading me and don't need to keep me anymore. Or worse (boo-hoo), you don't need me and don't even want me. In either case, please take me somewhere where I can help someone else. Take me to your library. Take me to your doctor, therapist, or local mental health clinic. Take me to your leader. But please, please, don't throw me away.

The OCD Foundation of Michigan
Mission Statement

- To recognize that Obsessive-Compulsive Disorder (OCD) is an anxiety-driven, neurobiobehavioral disorder that can be successfully treated.
- To offer a network of information, support, and education for people living with OCD, their families and friends, and the community.

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