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!

Summer 2013

OCD in the DSM-5

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is published by the American Psychiatric Association (APA) and serves as the universal authority for the diagnosis of psychiatric disorders. This spring marked the release of the Fifth Edition of the DSM (DSM-5). In this issue of ***Never Say Never***, we will look at the changes in the DSM-5 over the DSM-IV in its presentation of Obsessive-Compulsive Disorder and related disorders. A general overview of the changes will be found on page 4. A direct comparison of the Diagnostic Criteria for OCD follows on pages 6 and 7, and the changes for Trichotillomania (Hair-Pulling) appear on page 8. In addition to these changes, the DSM-5 defines two new disorders under the OCD classification: Hoarding and Excoriation (Skin-Picking). The hope is that, by reflecting the increasing evidence of these disorders' relatedness to one another and distinction from other anxiety disorders, clinicians will be better able to identify and treat individuals suffering from these disorders.

FALL PROGRAM, 1:00 SATURDAY, OCTOBER 12, 2013

Come to a free screening of the movie "OC87" by Bud Clayman, a movie maker who has documented his own experience with OCD and Asperger's. A fascinating movie that expresses the reality of living with these disorders. Bud Clayman himself (along with his co-directors Glenn Holsten and Scott Johnston) will join us (via Skype) to answer our questions. Don't miss this event.

Join us at Botsford Hospital, Administration & Education Center, Classroom A&B, 28050 Grand River Ave. (north of 8 Mile Rd.), Farmington Hills, MI. See our webpage, ocdmich.org, for flyer.

THE OCD FOUNDATION OF MICHIGAN

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* Thanks to Mark Fromm, President of Business Growth Today, Inc., for hosting our website.

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NEVER say NEVER

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a 501(c)(3) non-profit organization.

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
(in the Specialty Centers area)
5320 Elliott Drive, Ypsilanti, MI
Call Bobbie at (734) 522-8907 or (734) 652-8907
E-mail OCDmich@aol.com

DEARBORN:

2nd Thursday, 7-9 PM
First United Methodist Church
22124 Garrison Street (at Mason)
Call Joan at (734) 479-2416

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.

Teen Anxiety Group
1st, 3rd, and 5th Wednesday, 5:30 to 6:30 p.m.
Open to individuals who have any kind of anxiety problems as well as their friends and family members.

Adults Obsessive-Compulsive Disorders
Every Tuesday, 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.

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:

1st Wednesday, 7-9 PM
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
Meets in Private Dining Room
(If the building is locked, press the Security button next to the door, tell them you are there for a meeting, and they will buzz you in.)
Call Terry at (586) 790-8867
E-mail tmbrusoe@att.net

Overview of DSM-5 Changes

Written by Elizabeth Rosenfield
Massachusetts General Hospital OCD and Related Disorders Program

Have you ever wondered how mental disorders are created, organized, and diagnosed? Who decides the specific criteria for each disorder? How does a clinician know how to diagnose someone a particular disorder? In the United States, many of the answers to these questions stem back to a big book called the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM is a guidebook that clinicians and researchers use in order to most accurately diagnose and classify mental disorders. Since its conception in 1952, the DSM has undergone several iterations as professionals in the field continue to improve our understanding of mental disorders and their classification. The year 2013 happens to be a particularly exciting time in the rich history of the DSM as it marks the publication of the fifth edition of this important manual. After years of research, meetings, discussions, and revisions, the American Psychological Association (APA) has approved the final diagnostic criteria for the new DSM-5.

The APA has revised the DSM with the sincere hope that this changes will lead to better detection, diagnosis, and treatment of mental disorders. The DSM-5 will have a new chapter structure in which disorders that appear similar to one another with regard to symptoms and underlying causes will be grouped together in chapters, of which there are 20 in total. As the OCD and Related Disorders program, we are particularly interested in the novel additions and intriguing changes to disorders classified under the Obsessive Compulsive and Related disorders chapter. We'll review and discuss some of these revisions below!

Obsessive Compulsive Disorder

What's different about Obsessive Compulsive Disorder (OCD) in DSM-5? Somewhat controversially, obsessive compulsive disorder has been removed from the anxiety disorders and given its own chapter referred to as Obsessive Compulsive and Related Disorders. This chapter, beginning with OCD, includes several disorders thought to be related to OCD, including Hoarding Disorder, Body Dysmorphic Disorder, Hair Pulling and Excoriation Disorder (previously, Skin Picking). Most other changes to OCD in the DSM-5 relate to the semantics of the diagnostic criteria. More specifically, the term impulse has been replaced with the word urge in order to more accurately capture the nature of obsessions. The APA opted to change the word "inappropriate" to the word "unwanted" to describe obsessions in OCD, given that the meaning of "inappropriate" can vary widely depending on one's culture, gender, age etc. Finally, a few criteria have been removed from the DSM-IV definition of OCD including that individuals must recognize their obsessions and/or compulsions as unreasonable or excessive.

Hoarding Disorder

Historically, hoarding has been characterized as an obsessional characterological trait. Its origins as such can be linked to the psychoanalytical construct of the "anal character", which has transformed into Obsessive Compulsive Personality Disorder in more recent diagnostic terms. In DSM_IV, hoarding was classified as a symptom of OCD and not considered its own diagnosis.

Due to more research and public discourse on hoarding in recent years, hoarding has been removed as a symptom of OCD and Hoarding Disorder (HD) has been added as an independent disorder. The first criteria for HD in DSM-5 state that the person must experience, "persistent difficulty parting with possessions regardless of their ac-

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tual value." Notably, in contrast to previous editions, these criteria avoid making explicit judgments about the value of the hoarded possessions. Rather, they focus on the perceived need to save the items and associated distress. According to the DSM-5, this difficulty parting with possessions must result in "the accumulation of possessions that congest and clutter active living areas and substantially compromise their intended use." This criterion is designed to capture a hallmark of hoarding and one often highlighted in popular media: clutter. Although the clutter shown in TV shows is often quite extreme with piles of clothes and papers reaching the ceiling and covering every inch of the floor, the DSM-5 criteria emphasize the functionality of the living space rather than how much physical space is used up by the possessions. Finally, the DSM-5 includes a specifier as to whether symptoms of hoarding are accompanied by excessive collecting or stealing of items. This specifier represents a departure from previous conceptions of hoarding which conceded that all individuals with hoarding acquire excessively. With these new criteria, individuals who suffer from hoarding, but do not acquire excessively, will still be able to receive the diagnosis of HD.

Body Dysmorphic Disorder

Because of its focus on the body, Body Dysmorphic Disorder has historically been classified as a somatoform disorder. However, in DSM-5, BDD will be moved to the Obsessive Compulsive and Related Disorders chapter to reflect its similarities in presentation and treatment to OCD.

In addition to adjusting BDD's structural placement within the manual, the DSM-5 includes a few changes with regard to the BDD diagnostic criterion. The criteria for BDD include, "preoccupation with one or more perceived defects or flaws in appearance that are not observable or appear slight to others." This represents a change from the DSM-IV criteria which describe the individual's "defects or flaws in appearance" as imagined, instead of perceived. Although these "flaws" may seem imagined to friends and family members of the person suffering from BDD, these imperfections may seem incredibly real to the individual. Thus, the wording has been changed to more accurately capture the experience of individuals with BDD. The DSM-5 diagnostic criteria additionally feature a newly added criteria that at some point during the disorder, the person has performed repetitive behaviors (mirror checking, grooming, etc.) or mental acts (comparing appearance to others) in response to their appearance concerns. This criterion is consistent with the symptomotology of BDD and reflects BDD's position in the Obsessive Compulsive and Related Disorders chapter. Notably, the DSM-V criteria also include a specifier for muscle dysmorphia (the belief that one's body is too small or insufficiently muscular), a subtype of BDD. See our muscle dysmorphia blog post for more information.

Other disorders in the Obsessive Compulsive and Related Disorders chapter include Excoriation Disorder (Previously, Skin Picking and a new addition to the DSM-5) and Hair Pulling Disorder (named changed from Trichotillomania). The DSM-5 is scheduled to be released in the spring of 2013. Stay tuned to our website and twitter for more information on its release!

This article can be found at https://mghocd.org/dsm-5/

DSM-IV
Obsessive Compulsive Disorder (OCD) Criteria

A. Either obsessions or compulsions:

Obsessions as defined by (1), (2), (3), and (4):

(1) recurrent and persistent thoughts, impulses, or images that are experienced at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress

(2) the thoughts, impulses, or images are not simply excessive worries about real-life problems

(3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action

(4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Compulsions as defined by (1) and (2):

(1) repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly

(2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. Note: This does not apply to children.

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

DSM-5
Obsessive-Compulsive Disorder
Diagnostic Criteria

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

(1) Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.

(2) The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):

(1) Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.

(2) the behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive. **Note:** Young children may not be able to articulate the aims of these behaviors or mental acts.

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in Trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating behavior, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behavior, as in autism spectrum disorder).

Diagnostic Criteria for Trichotillomania

In DSM-IV, listed under "Impulse Control Disorders"

A. Recurrent pulling out of one's hair resulting in noticeable hair loss.

B. An increasing sense of tension immediately before pulling out the hair or when attempting to resist the behavior.

C. Pleasure, gratification, or relief when pulling out the hair.

D. The disturbance is not better accounted for by another mental disorder and is not due to a general medical condition (e.g., a dermatological condition).

E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

In DSM-5, listed under "Obsessive-Compulsive and Related Disorders"

A. Recurrent pulling out of one's hair, resulting in hair loss.

B. Repeated attempts to decrease or stop hair pulling.

C. The hair pulling causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The hair pulling or hair loss is not attributable to another medical condition (e.g., a dermatological condition).

E. The hair pulling is not better explained by the symptoms of another mental disorder (e.g., attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder).

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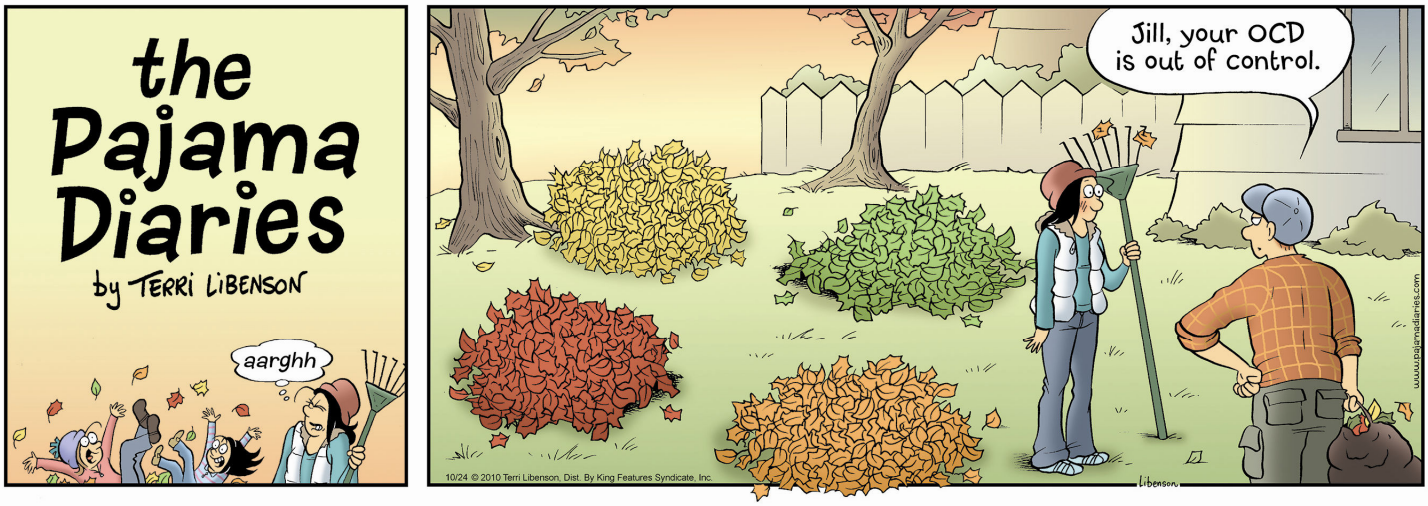
Always get the latest news and events. Go to our Facebook page, www.facebook.com/pages/The-OCD-Foundation-of-Michigan/192365410824044 and click "Like".



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Spirituality – Can Prayer Have An Effect On OCD?

By Kay Zeaman

As the director of research at the Myrna Brind Center for Integrative Medicine at Thomas Jefferson University Hospital and Medical College in Philadelphia, Dr. Andrew Newberg has studied the impact of religious practice and meditation on the human brain for more than 17 years. Dr. Andrew Newberg is one of the founders of the field of ***neurotheology***, defined as the study of the relationship between the brain and religious and spiritual phenomena. Through his research he has studied the brain scans of more than 150 people to observe the various changes that take place during religious practice/meditation. He is co-author of, among other books, ***How God Changes Your Brain***.

The results of Dr. Newberg's research can be found in the October, 2011 issue of the Mind Health Report. Briefly, he found a relationship between religious practice/meditation and less depression, deactivation of the amygdala (key brain region where emotional processing takes place), improved concentration and calmness, a longer life and enhanced mental function.

People with OCD can relate to these findings as they have hyperactivity in the caudate nucleus, which has the function of evaluating, perceiving, and choosing appropriate responses. The caudate nucleus is connected to the orbit frontal cortex and this hyperactivity causes people with OCD to get caught up in repetitive behaviors. Brain scans have shown that people with OCD often have abnormalities with the brain, particularly in the orbital cortex (the part of the brain above the eyes) and in deeper structures such as the basal ganglia and thalamus. Brain scans used by Dr. Newberg's research team showed that intense meditation alters our gray matter, strengthening regions that focus the mind and foster compassion while calming those linked to fear and anger.

Dr. Newberg's research also demonstrated that prayer deactivates the more primitive or "reptilian" region of the brain (the limbic system). This region includes the amygdala, hypothalamus, and cingulate cortex. The limbic system is associated with anger, guilt, anxiety, depression, fear, resentment, and pessimism. The amygdala, the almond-shaped part of the midbrain, activates the anxiety 'flight or fight' response that prepares the body to either flee from, or fight, a perceived threat. In people with OCD, a threat is perceived when in fact there is no danger.

Another individual who has explored the role of spirituality in healthcare is physician Larry Dossey. He has stated that he would not withhold prayer for a patient any more than he would

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withhold an antibiotic if needed. Two of the many books he has written are ***Healing Words: The Power of Prayer and the Practice of Medicine*** and ***Prayer is Good Medicine: How to Reap the Healing Benefits of Prayer***.

Dr. Dossey states that an urge toward wholeness, which underlies all great religions, is the most elemental quality of prayer. The feeling that one is being drawn toward something higher, greater, deeper is expressed by mystics as the Divine Union or merging with the Absolute. It is also one of the tenets of Jungian psychology.

Through his search for empirical evidence in prayer's effectiveness, Dr. Dossey was able to integrate the scientific with the spiritual, shattering the long-held notion that these doctrines are exclusive. He often refers to various laboratory experiments in the power of intercessory prayer such as those by Dr. William G. Braud and colleagues in San Antonio, Texas. They conducted a series of exemplary experiments that demonstrated that the prayer (mental images) of one person can modify the activity of the autonomic nervous system of a distant person, even when the "receiver" is unaware of the prayer. This may be comforting for persons with OCD who have supportive friends and family, knowing that their prayers, along with their own, can positively impact their lives.

Kay Zeaman is an OCDFM Board member who is always looking for interesting, alternative methods of addressing OCD.

Words of Wisdom

Life is either a daring adventure or nothing. Avoiding danger is no safer in the long run than exposure." ***- Helen Keller***

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 gain strength, courage, and confidence by every experience in which you really stop to look fear in the face. You must do the thing which you think you cannot do.
- Eleanor Roosevelt

FROM OUR MEMBERS

We all have our own feelings about our OCD, about how it has impacted our lives. The OCD Foundation of Michigan would like to hear about your personal experience. Here, member Amit Kshirsagar shares a couple of his writings, the first an article he wrote for the ***Ann Arbor Journal*** in 2010, and the second, for ***Connections***, the newsletter of NAMI Washtenaw County, in 2008. Amit reports that since the time of these writings, he has earned his Masters in Statistics from Eastern Michigan University, and hopes to marry some day.

Staying employed especially difficult for sufferers of OCD

By Amit Kshirsagar

Occupational disability is a serious consequence for patients who suffer from obsessive-compulsive disorder, according to a statistical investigation through a sample survey.

The study used regression analysis to reveal that the severity of a patient's symptoms of obsessive-compulsive disorder is the most important cause of occupational disability. The study was based upon a large enough sample size of 238 patients and a control group to be statistically valid.

People who suffer from moderate to severe symptoms of OCD are either simply unable to work, or if they do find suitable employment, they are soon terminated from most places of employment due to their inability to focus or to strictly adhere to the demands of their employers' expectations, based only on seemingly "normal" employees' behavior.

Obsessive-compulsive disorder is a strange-but-chronic psychiatric emotional disorder that affects approximately 1.6 to 3 percent of the worldwide workforce population.

This disorder is particularly strange in that, on the one hand, its sufferers appear to be quite capable, intelligent-looking individuals, who appear to be normal, with seriousness in their gaze and uprightness in their posture, since any attempts to appear smiling would be seen as artificial.

Most Asian Indians, especially second-generation immigrants, are expected to become doctors or engineers. In countries like India, if a pre-med student fails at medical college entrance exams, he or she often contemplates suicide rather than face the humiliation and loss of prestige within his or her privileged social circle.

With a society that is so much infatuated with grades and exam scores, it is no wonder that they are victims of a kind of systemic obsessive-compulsive disorder. Very few parents want to admit that their children have this psychiatric disorder for fear of loss of face among their peers, and many are in a state of denial.

The severity of the symptoms of obsessive-compulsive disorder has been consistently related to the inability to perform efficiently and promptly (with almost no mistakes in the workplace in order to get promotion) and to adhere to the rigors of the workplace.

It has been revealed in a recent paper by Mancebo et al, that the quality of life among patients with clinically diagnosed OCD is very low, especially due to societal intolerance for failure and stigmatization.

These findings also reveal that the occupational disability of patients who suffer from OCD is comparable to the disability rates of those individuals who suffer from panic disorder, major depressive disorder and body dysmorphic disorder.

What is most startling is the

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Staying Employed
(Continued from page 11)

fact that the swiftness with which they are released from their workplace duties contributes more to their seemingly sudden relapse of symptoms than if they would have simply been shown a little extra compassion and concern by their employers.

OCD is an invisible disability which many employers simply do not understand. They do not do so intentionally.

However, they do see the applicant as a strong, capable person and often fail to understand why he or she is unable to perform like a "normal" person.

To the person who suffers from OCD, the world often seems cruel, as it does not tolerate non-normal persons.

Since they are unable to get employment, their parents get frustrated, feel dejected and as a result, become extremely angry. Hence, they are unable to cope with this emotionally very painful situation. This creates an unhealthy atmosphere in the household, as OCD sufferers are constantly reminded about how "useless" they are. This in turn creates more frustration and the inability to work efficiently becomes much worse. This feeling of being "no good" gives rise to suicidal tendencies on the part of the patient and he becomes less social, shuts himself in his room, and, as a result, he gets more irritable and angry at the world. Thus, the individual remains further isolated and alone in a restricted environment.

What is required is some developmental and occupational education institution. Ann Arbor's Center for Independent Living is an organization like this, but it only caters to the needs of persons who have visible disabilities arising from birth defects or accidents. They need to extend their services to OCD patients also, as they are unable to perform and do not get any gainful employment.

Has the world become cold and become compassionless?

PERSONAL EXPERIENCE OF OCD

By Amit Kshirsagar

I was first diagnosed with obsessive-compulsive disorder in November 1989, when there was a rumor that the AIDS virus had hit Ann Arbor Pioneer High School. I developed an almost uncontrollable fear of contaminated hypodermic needles, as well as prolonged fear of contamination and germs. I became depressed and lost interest in things I had once enjoyed.

My experience is that society regards any psychiatric disorder as taboo and categorizes the person as insane. Since I appear to be able bodied, people look at me and seem to think "I really don't understand! If this guy is so tall and able bodied, why is he the only one not playing with us?" When I try to explain to them that I have OCD, they react with puzzlement and shock. People try to avoid me after hearing of my OCD.

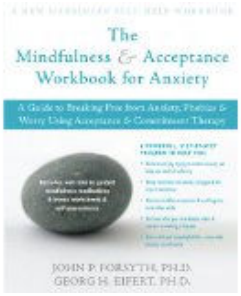
To avoid such comments and "that look," I became more unsocial and avoided social get-togethers, camping, events such as weddings etc., and got more and more depressed and bitter. I became angrier and resigned myself to being unable to get any reasonable job, in spite of my higher education. Dating was out of the question, and marriage was an impossibility. I avoided people, and they in turn began to avoid me, probably thinking that I did not want to mix with anyone. It became a vicious circle.

What a person with obsessive-compulsive disorder needs most is compassion and understanding.

SUGGESTED READING

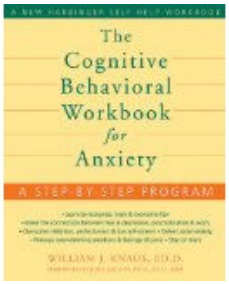
For the Summer 2013 Suggested Reading, we are focusing on anxiety disorders, of which Obsessive-Compulsive Disorder (OCD) is one. In many cases of OCD, another anxiety disorder co-occurs with it. Also, in all the anxiety disorders, the treatments are similar, both medication and psychotherapy.

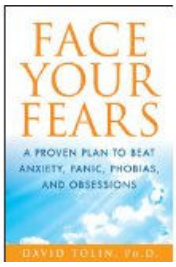
Self-help books



John P. Forsyth, PhD
Georg [no "e"] H. Eifert, PhD
The Mindfulness and Acceptance Workbook for Anxiety
New Harbinger Publications, Inc., 2008
ISBN 978-1-57224-499-3

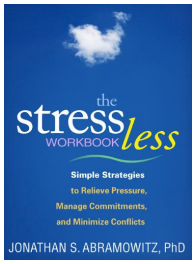
William J. Knaus, EdD
The Cognitive Behavioral Workbook for Anxiety
New Harbinger Publications, Inc., 2008
ISBN 978-1-57224-572-3



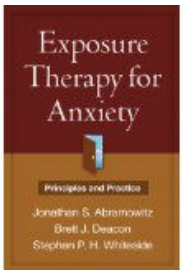


David Tolin, PhD
Face Your Fears
John Wiley and Sons, Inc., 2012
ISBN 978-1-118-01673-2

Jonathan H. Abramowitz, PhD
The Stress Less Workbook
The Guilford Press, Inc., 2012
ISBN 978-1-60918-471-1

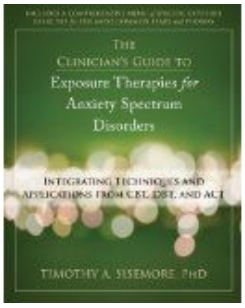


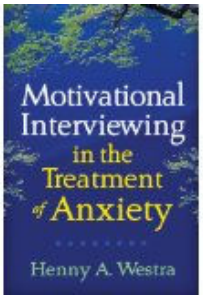
Professional books



Jonathan S. Abramowitz, PhD
Exposure Therapy for Anxiety
The Guilford Press, Inc., 2011
ISBN 978-1-60918-016-4

Timothy A. Sisemore, PhD
The Clinicians Guide To Exposure Therapies for Anxiety Spectrum Disorders
New Harbinger Publications, Inc., 2012
ISBN 978-1-60882-152-5





Henry A. Westra, PhD
Motivational Interviewing in the Treatment of Anxiety
The Guilford Press, Inc., 2012
ISBN 978-1-4625-0481-7

BULLETIN BOARD

TELL US YOUR STORY

You've told us what you want to see in your newsletter - more personal stories. What is OCD like for you? How has it affected your life? How have you dealt with it? What advice do you have for others? We would like to hear your stories and include them in these pages. Send your story to OCDFM, P.O. Box 510412, Livonia, MI 48151-6412, or e-mail to OCDmich@aol.com.

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.

Help is Still Wanted

The OCD Foundation of Michigan is still looking for individuals who would like to serve on the Board of Directors. Have you ever felt the desire to help out your Foundation? Are you passionate about helping others with OCD? Have you been helped by the Foundation and want to give back? The commitment is small. The Board meets only once a month. Beyond that, you can put in only as much time as you wish. If you're interested, call (734) 466-3105 or e-mail OCDmich@aol.com.

PROFESSIONAL DIRECTORY

List with us

Treatment professionals, what better way to find the OCD sufferers who need your help, and to give them a way to find you. Just place your business card in ***Never Say Never***, the quarterly newsletter of The OCD Foundation of Michigan. For just $25.00 per issue, your card can be in the hands of the very people who need you most. It's a great way to reach out to the OCD community, and at the same time support The OCD Foundation of Michigan. Send your card to OCDFM, P.O. Box 510412, Livonia, MI 48151-6412, or e-mail to OCDmich@aol.com. For more information, call 734-466-3105.

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PLEASE HELP

The OCD Foundation of Michigan is funded solely by your annual membership fees and additional donations. We have no paid staff. All work is lovingly performed by a dedicated group of volunteers. WHY NOT VOLUNTEER YOUR TIME? Call 734-466-3105 or e-mail OCDmich@aol.com.

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Please Print:

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Phone Number: _____ E-mail Address: _____

May we send you newsletters, notices and announcements via e-mail? _____

- ❑ **Enclosed please find my check for $20 annual membership fee.**
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Make check or money order payable in U.S. funds to
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8/2013

Please Don't Throw Me Away

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.

IF YOU WOULD LIKE TO BE ADDED TO OR DELETED FROM THE MAILING LIST PLEASE CONTACT US

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