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!

Fall 2013/Winter 2014

Ten Things You Need To Know To Overcome OCD

By Fred Penzel, Ph.D.

I have been actively involved in the treatment of OCD since 1982, and have treated over 850 cases of the disorder. During that time, I have come to many valuable understandings that I believe are important tools for anyone planning to take on this disorder. Putting together this type of list always seems arbitrary in terms of what to include, but suffice it to say, however it is presented, there is a certain body of information that can make anyone's attempts at recovery more effective.

Some of these points may seem obvious, but it has always struck me as remarkable how little of this information my new patients, who are otherwise intelligent and informed people, are seen to possess coming into therapy.

You may not like some of the things on this list, as they may not be what you wish to hear. You don't have to like them. However, if you wish to change, you will need to accept them. The concepts of change and acceptance go hand-in-hand, and define each other. There are some things you will be able to change, and some you will have to accept. It is important to discriminate between the two, so as to not end up misdirecting your efforts.

My list is as follows:

1. OCD is chronic.

This means it is like having asthma or diabetes. You can get it under control and become recovered but, at the present time, there is no cure. It is a potential that will always be there in the background, even if it is no longer

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SPRING PROGRAM - TO BE ANNOUNCED

Keep watching your e-mail, our website ocdmich.org, or our Facebook page for details TBA.

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NEVER say NEVER

is the quarterly newsletter of The OCD FOUNDATION OF MICHIGAN,
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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:

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
NOTE NEW LOCATION FOR 2014
The John & Marnie Demmer Wellness Pavilion
820 Arlington Ave.
Petoskey, MI 49770
Call Kevin 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

Defining OCD

BUD CLAYMAN INTERVIEWS OCD SPECIALIST JON HERSHFIELD

Bud Clayman: I'm going to jump right in. What is Obsessive Compulsive Disorder? Please define it for me.

Jon Hershfield: That's an easy one. That's what I work with all day, every day.

Obsessive Compulsive Disorder is one of the disorders that's easily defined by its own name. So you have obsessions which are unwanted, intrusive thoughts – sometimes [they] come with images, feelings, impulses urges but [they] are generally referred to as thoughts.

You have compulsions which are behaviors or rituals that you engage in to relieve the discomfort associated with having those unwanted thoughts. And then you've got this word disorder which basically means it's sort of an exaggeration of a normal experience.

So if you were to look in the DSM, what you would see is that one of the criteria is that dealing with these obsessions and compulsions take more than an hour of your time every day. The average OCD sufferer would probably be reading this interview going, "An hour? That sounds nice."

So [with] Obsessive Compulsive Disorder, you have obsessions, you have compulsions, and they create this kind of cycle, this loop, and dealing with those unwanted, intrusive thoughts and trying to respond to them in such a way that relieves your discomfort is consuming a significant part of your day.

Bud Clayman: What are the various types of obsessions or intrusive thoughts that people might have?

Jon Hershfield: Well, they can pretty much run the gamut only because it's sort of up to you what you decide is an acceptable or unacceptable thought to have. As a psychiatric illness, there's so many different ways of looking at where this is coming from, genetic, learned, experiential, and you can pretty much have an obsession about anything.

But I can tell you some of the more common ones that I see during treatment. The most familiarized in the media would be contamination obsession. It's sort of easy to portray on film.

This would be an obsessive concern with cleanliness, with germs, a fear of getting sick, a fear of being disgusted by things that you associate with disgust, things related to the toilet, bodily fluids, substances, chemicals, etcetera, etcetera. The compulsions would be varying degrees of avoidance and trying to clean and trying to neutralize whatever it is you think has gotten on you that you might spread or you might get in your body.

Other common obsessions that you probably don't see as popularized in the media would be obsessions where a lot of the related compulsions are a little bit harder to notice, they're a little bit more covert. So this would be bad thought-types of obsessions. Harm obsession is very common. [This is] intrusive thought[s] of a violent or aggressive nature. What if I were to hurt a family member or what if I were to push a stranger off a ledge or self-harm obsessions. What's to stop me from hurting myself?

Sexual obsessions are very common. What if I were gay and didn't know it? Or if you're gay, "What if I were straight and didn't know it?" What if something is wrong with me sexually? What if I'm living in denial? Obsessions about harming children, either physically or sexually or both are very common.

Relationship obsessions are also very common. What if I'm not with the right person? How do I know I'm not in denial? What if I don't really love my wife? Or what if I love my husband and it's fake somehow or wrong somehow?

Religious obsession is another common one. Scrupulosity, how do I know for sure that I'm connected to my faith or that I'm not practicing my faith the wrong way? What if this intrusive thought is blasphemous and I'm going to be punished for it?

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I think that hits the most common ones.

Bud Clayman: As you know from the [film] OC87 that I did, I suffer from Harm OCD. I wanted to focus on that a bit. Can you go more into what Harm OCD is and how it's treated and especially can you talk about what's known as exposure response prevention and how cognitive behavior therapy comes into play with that disease?

Jon Hershfield: Absolutely. So as I mentioned before, Harm OCD is a really common form of OCD although a lot of people are apprehensive about getting treatment because, you know, the core of the fear is what if I'm essentially a closeted sociopath. What if these intrusive thoughts that might be hammering you all day, you look at a person, you think, "I want to hurt that person. I want to stab that person," or, "What if I just pushed that person?" Then you think, "Well, wait a minute. That's not who I am. That's not what I want. Why am I having these thoughts?" The moment you start asking yourself why you are having these thoughts, you're already sent down this path of trying to investigate, explain to yourself, rationalize to yourself that you're a good person.

Because this really doesn't give you a sense of certainty that you would never cause harm to another human being, you end up on this endless quest for certainty, [and do] compulsions. A common compulsion in Harm OCD would typically be things that involve avoiding being around people, neutralizing your thoughts, repeatedly telling yourself self-reassuring things. "I would never do that. I'm not a bad person," and avoiding any triggering media, the news, knives, and weapons, and things like that and various other sort of mental rituals [such as] trying to force yourself to think positive thoughts of safety as a direct response to the negative and intrusive thoughts about hurting.

Bud Clayman: And that doesn't really work, right?

Jon Hershfield: No, it actually backfires because you already know in your heart of hearts that you're a pretty much normal, decent human being that doesn't have any desire to hurt anyone.

Bud Clayman: Let me just stop you for a second because I [have] a lot of anger issues so how would that come into play there because sometimes I don't know that I'm a good human being.

Jon Hershfield: Well, "know" is a tricky word. What I mean – when we say we know something, we're basing it on evidence. "I know the sky is blue because every time I look up there, it seems to be blue to me." That's enough for me to say that I know and yet it's not something I can really prove with 100% certainty. When we say, "I know I don't want to hurt anyone," it's sort of, "Well, let's look at the evidence. Do you have a long history of physically attacking people? Do you get pleasure out of physically attacking someone?"

Bud Clayman: No.

Jon Hershfield: So okay, if there's not a lot of evidence but we have these thoughts –

Bud Clayman: But sometimes I'd like to – I think that's what worries me. And after that [it] gets hooked into my OCD.

Jon Hershfield: Well, this is something that you would probably want to work on with your therapist because the notion of liking a thought or even liking the experience of anger is still not providing any evidence of what you would actually do given the opportunity.

I recently, on a whim decided to buy the game, "Grand Theft Auto Five." I've been toying around with it for a little bit and probably my favorite thing to do is get up on a rooftop with a sniper gun and just take out innocent people.

Bud Clayman: No way.

Jon Hershfield: I don't know, but it seems to give me pleasure. This is not an indicator of what I'm going to do at work today. I presume. So this notion of liking a thought that's incongruent with your identity, a lot of OCD sufferers really get caught up because they want certainty and they can't have it. It's not a thing that exists.

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You asked me about exposure and [response prevention]. The real problem here is that you have thoughts which are normal events about things that could happen, that are very unlikely to happen but could happen. Anything could happen. The world could explode in a moment. We have thoughts about something that could happen.

I could hurt this person and the objective reality is that yes, technically you're capable of hurting this person and the only thing between you and hurting this person is the decision not to do it.

So, you're having this thought and it's trying to get through you. It's trying to go through a pathway in your mind along with other thoughts like what's for breakfast and what day is it and when's this bus coming and things like that. You're putting up a roadblock. You're saying, "This thought can't be in my mind because if this thought's in my mind, it means that I'm going to do something bad and I could never live with myself if I did something bad."

When you put up that roadblock, you start to feel discomfort. You start to feel anxiety because the thought gets stuck. So, one of the main treatment protocols that we use in treating OCD is exposure with response prevention which is a part of cognitive behavioral therapy. What it means is you come up with strategies to expose yourself to these unwanted thoughts, basically bring the thought into your presence on purpose and then you experience the discomfort that it causes you.

Then you try to prevent the response of a ritual or a compulsion which would be to reassure yourself or to shut the thought down or avoid what's causing the thought and what that does, although it's a very uncomfortable experience, is it forces you to let that thought go through you. It's basically – you know, you're saying, "You shall not pass – okay, fine. You can pass."

Then the thought passes through you and then you repeat this. And as you're repeating this over and over, this pathway sort of opens up and allows the thought to go through you. As a sufferer, this is a very, very challenging experience because you are thinking that you're going to harm someone, feeling like you're going to harm someone but you're not behaving like you're going to harm someone. Because if you didn't have Harm OCD, that's how you would be responding to this thought. You'd go like, "Oh, that's a weird thought." But it passed.

As you practice that, you get better at it and once you start to notice it, the thoughts start to present themselves as less intrusive, less offensive, and with less bite and with less bite, there's less anxiety and with less anxiety and discomfort, there's less of an urge to do compulsions, and with less compulsions there's less fueling the obsession. And around and around we go and that's how people get better.

But exposure therapy is very hard to do. You really need to have a plan. You need to really kind of structure a plan of how you're going to gradually expose yourself to this thing that you're afraid of and a lot of times that really requires the help of a true provider that specializes in OCD which is not to say they can't necessarily be done on your own. But it certainly can help to have an outsider's perspective who really understands OCD.

*Bud Clayman is a moviemaker who suffers from OCD and Asperger's. We screened his movie **"OC87: The Obsessive Compulsive, Major Depression, Bipolar, Asperger's Movie,"** in October 2013, and then talked with him and his co-directors via Skype. In addition to his website oc87.com, he also has a site called oc87recoverydiaries.com. This interview is the first of a series of four that Bud conducted with therapist Jon Hershfield.*

*Jon Hershfield, MFT is a psychotherapist in private practice in Los Angeles and the associate director of the UCLA Child OCD Intensive Outpatient Program. His book is **The Mindfulness Workbook for OCD: A Guide to Overcoming Obsessions and Compulsions using Mindful and Cognitive Behavioral Therapy** by Jon Hershfield MFT, Tom Corboy MFT, and James Claiborn PhD ABPP (Foreword).*

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affecting your life. The current thinking is that it is probably genetic in origin, and not within our current reach to treat at that level. The things you will have to do to treat it are really controls, and if you don't learn to effectively make use of them throughout your life, you will run the risk of relapse. This means that if you don't use the tools provided in cognitive/behavioral therapy or if you stop taking your medication (in most cases) you will soon find yourself hemmed in by symptoms once again.

2. Two of OCD's main features are doubt and guilt.

While it is not understood why this is so, these are considered hallmarks of the disorder. Unless you understand these, you cannot understand OCD. In the 19th century, OCD was known as the "doubting disease." OCD can make a sufferer doubt even the most basic things about themselves, others, or the world they live in. I have seen patients doubt their sexuality, their sanity, their perceptions, whether or not they are responsible for the safety of total strangers, the likelihood that that they will become murderers, etc. I have even seen patients have doubts about whether they were actually alive or not. Doubt is one of OCD's more maddening qualities. It can override even the keenest intelligence. It is a doubt that cannot be quenched. It is doubt raised to the highest power. It is what causes sufferers to check things hundreds of times, or to ask endless questions of themselves or others. Even when an answer is found, it may only stick for several minutes, only to slip away as if it was never there. Only when sufferers recognize the futility of trying to resolve this doubt, can they begin to make progress.

The guilt is another excruciating part of the disorder. It is rather easy to make people with OCD feel guilty about most anything, as many of them already have a surplus of it. They often feel responsible for things that no one would ever take upon themselves

3. Although you can resist performing a compulsion, you cannot refuse to think an obsessive thought.

Obsessions are biochemically generated mental events that seem to resemble one's own real thoughts, but aren't. One of my patients used to refer to them as "My synthetic thoughts." They are as counterfeit bills are to real ones, or as wax fruit is to real fruit. As biochemical events, they cannot simply be shut off at will. Studies in thought suppression have shown that the more you try to not think about something, the more you will end up thinking about it paradoxically. The real trick to dealing with obsessions I like to tell my patients is, "If you want to think about it less, think about it more." Neither can you run from or avoid the fears resulting from your obsessions. Fear, too, originates in the mind, and in order to recover, it is important to accept that there is no escape. Fears must be confronted. People with OCD do not stay with the things they fear long enough to learn the truth--that is, that their fears are unjustified, and that the anxiety would have gone away anyway on its own, without a compulsion or neutralizing activity.

4. Cognitive/Behavioral Therapy is the best form of treatment for OCD.

Cognitive/Behavioral Therapy (CBT) is considered to be the best form of treatment for OCD. OCD is believed to be a genetically-based problem with behavioral components, and not psychological in origin. Ordinary talk therapy will, therefore, not be of much help. Reviewing past events in your life, or trying to figure out where your parents went wrong in raising you have never been shown to relieve the symptoms of OCD. Other forms of behavioral treatment, such as relaxation training or thought-stopping (snapping a rubber band against your wrist and saying the word "Stop" to yourself when you get an obsessive thought) are likewise unhelpful. The type of behavioral therapy shown to be most effective for OCD is known as Exposure and Response Prevention (E&RP).

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E&RP consists of gradually confronting your fearful thoughts and situations, while resisting the performing of compulsions. The goal is to stay with whatever makes you anxious so that you will develop a tolerance for the thought or the situation, and learn that, if you take no protective measures, nothing at all will happen. People with OCD do not stay long enough in feared situations to learn the truth. I try to get my patients to stay with fearful things to the point where a kind of fatigue with the subject sets in. Our goal is to wear the thought out. I tell them, "You can't be bored and scared at the same time." Compulsions, too, are part of the system and must be eliminated for the recovery process to occur. There are two things that tend to sustain compulsions. One is that by doing them, the sufferer is only further convinced of the reality of their obsessions, and is then driven to do more compulsions. The other is that habit also keeps some people doing compulsions, sometimes long after the point of doing them is forgotten. The cognitive component of CBT teaches you to question the probability of your fears actually coming true (always very low or practically nil), and to challenge their underlying logic (always irrational and sometimes even bizarre).

5. While medication is a help, it is not a complete treatment in itself.

It is human nature to always want quick, easy, and simple solutions to life's problems. While everyone with OCD would like there to be a magical medicinal bullet to take away their symptoms, there really is no such thing at this time. Meds are not the "perfect" treatment; however, they are a "pretty good" treatment. Generally speaking, if you can get a reduction in your symptoms of from 60 to 70 percent, it is considered a good result. Of course, there are always those few who can say that their symptoms were completely relieved by a particular drug. They are the exception rather than the rule. People are always asking me, "What is the best drug for OCD?" My answer is, "The one that works best for you." I have a saying about meds: "Everything works for somebody, but nothing works for everybody." Just because a particular drug worked for someone you know, does not mean that it will work for you.

Relying solely upon meds most likely means that all your symptoms will not be relieved and that you will always be vulnerable to a substantial relapse if you discontinue them. Discontinuation studies (where those who have only had meds agreed to give them up) have demonstrated extremely high rates of relapse. This is because drugs are not a cure, but are rather a control. Even where they are working well, when you stop taking them, your chemistry will soon revert (usually within a few weeks) to its former unhealthy state. Meds are extremely useful as part of a comprehensive treatment together with CBT. They should, in fact, be regarded as a tool to help you to do therapy. They give you an edge by reducing levels of obsession and anxiety. While those with mild OCD can frequently recover without the use of meds, the majority of sufferers will need them in order to be successful. One unfortunate problem with meds is the stigma attached to them. Having to use them does not mean that you are weaker than others, only that this is what your particular chemistry requires for you to be successful. You can't always fight your own brain chemistry unaided. Using psychiatric drugs also does not mean that you are "crazy." People with OCD are not crazy, delusional, or disoriented. When relieved of their symptoms, they are just as functional as anyone.

6. You cannot and should not depend upon the help of others to manage your anxiety or to get well.

To begin with, and most obviously, you are always with you. If you come to depend upon others to manage your anxiety by reassuring you, answering your questions, touching things for you, or taking part

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in your rituals, what will you do when they are not around? My guess is that you will likely be immobilized and helpless. The same is true if you only work on your therapy homework when others are nagging or reminding you. No one can want you to recover more than you do. If your motivation is so poor that you cannot get going on your own (assuming that you are not also suffering from an untreated case of depression), then you will have learned nothing about what it takes to recover from OCD. As mentioned at the beginning, since OCD is chronic, you will have to learn to manage it throughout your life. Since you can find yourself on your own at any point, unpredictably, you will always need to be fully independent in managing it.

7. The goal of any good treatment is to teach you to become your own therapist.

In line with the last point, good Cognitive/Behavioral treatment should aim to give you the tools necessary to manage your symptoms effectively. As therapy progresses, the responsibility for directing your treatment should gradually shift from your therapist to you. Whereas the therapist may start out by giving you assignments designed to help you face and overcome your fears, you should eventually learn to spot difficult situations on your own and give yourself challenging homework to do. This will then be a model for how you will need to handle things throughout your life.

8. You cannot rely upon your own intuition in deciding how to deal with OCD.

In using your intuition to deal with what obsessions may be telling you, there is one thing you can always count on: it will always lead you in the wrong direction. It is only natural to want to escape or avoid that which makes you fearful. It's instinctive. It really amazes me how common this is. This may be fine when faced by a vicious dog or an angry mugger but, since the fear in OCD results from recurring thoughts inside your head, it cannot be escaped from. The momentary escape from fear that compulsions give fools people into relying upon them. While compulsions start out as a solution, they soon become the main problem itself as they begin taking over your life. People with OCD never stay with what they fear long enough to find out that what they fear isn't true. Only by doing the opposite of what instinct tells you will you be able to find this out.

9. Getting recovered takes time.

How long does it take? As long as is necessary for a given individual. Speaking from experience, I would say that the average uncomplicated case of OCD takes from about six to twelve months to be successfully completed. If symptoms are severe, if the person works at a slow pace, or if other problems are also present, it can take longer. Also, some people need to work on the rehabilitation of their lives after the OCD is brought under control. Long-term OCD can take a heavy toll on a person's ability to live. It may have been a long time since they have socialized, held a job, or done every day household chores, etc. Some people have never done these things. Returning to these activities may add to the time it takes to finish treatment.

However long it takes, it is crucial to see the process through to the finish. There is no such thing as being "partially recovered." Those who believe they can take on only those symptoms they feel comfortable facing soon find themselves back at square one. Untreated symptoms have a way of expanding to fill the space left by those that have been relieved. When explaining this to my patients, I

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liken it to getting surgery for cancer. I ask them, "Would you want the surgeon to remove it all, or leave some of it behind?" Or, put another way, it is not a game you can simply drop out of midway with your winnings and expect to keep them.

10. Relapse is a potential risk that must be guarded against.

It has always been a favorite saying of mine that, "Getting well is 50 percent of the job, and staying well is the other 50 percent." We have actually come full-circle back to Point #1, which tells us that OCD is chronic. This tells us that although there is no cure, you can successfully recover and live a life no different from other people. Once a person gets to the point of recovery, there are several things that must be observed if they are to stay that way. As mentioned in Point #7, the goal of proper therapy is to teach people to become their own therapists. It gives them the tools to accomplish this. One of these tools is the knowledge that feared situations can no longer be avoided. The overall operating principle is that obsessions must therefore always be confronted immediately, and all compulsions must be resisted. When people are seen to relapse, it is usually because they avoided an obsessive fear which then got out of hand because they went on to perform compulsions. Another cause can be an individual believing that they were "cured" and stopping their medication without telling anyone. Unfortunately, the brain doesn't repair itself while on medications, and so when drugs are withdrawn, the chemistry reverts to its former dysfunctional state. Finally, some people may have fully completed their treatment, but have neglected to tell their therapist about all of their symptoms, or else they did not go as far as they needed to in confronting and overcoming the things they did work on. In pursuing treatment for OCD, it is vital to go the distance in tackling all of your symptoms, so as to be prepared for whatever you may encounter in the future.

It is vital to remember that no one is perfect, nor can anyone recover perfectly. Even in well-maintained recoveries, people can occasionally slip up and forget what they are supposed to be doing. Luckily, there is always another chance to re-expose yourself and so, rather than a person beating themselves up and putting themselves down, they can soon regain their balance if they immediately get back on track by turning again and facing that which is feared, and then not doing compulsions.

Finally, because health is the result of living in a state of balance, it is extremely important, post-therapy, to live a balanced life, with enough sleep, proper diet and exercise, social relationships, and productive work of some type.

*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.*

EMDR Therapy
(Eye Movement Desensitization and Reprocessing)

By Kay Zeaman

You may be wondering what an article on EMDR therapy, often used for PTSD (post traumatic stress disorder), is doing in an OCD newsletter. PTSD is all about uncontrolled bouts of high anxiety and OCD is an anxiety disorder. Getting relief from PTSD can significantly lower your anxiety level and directly or indirectly lessen OCD symptoms. I learned this from personal experience.

What exactly is EMDR and how does it work? EMDR therapy affects past experience, present experience, and future potential challenges resulting in decreased symptoms, elimination of distress from disturbing memories, improved view of self, and relief of body disturbances.

In my case, I worked with Dr. Janice DeLange in Grand Rapids. She is an EMDR therapist and trauma treatment specialist. Although there are different methods of doing EMDR therapy, Dr. DeLange used the method of moving her hand across my field of vision back and forth like the motion of a windshield wiper. My eyes followed the movement of her hand while I thought about the traumatic event in my life (the sudden death of my father).

After several repetitions of this movement I began to relive the traumatic event in very precise detail, experiencing physical and emotional feelings that were present at the time of the initial trauma.

My first OCD rituals started at the age of 11, three days after my father died suddenly in a car accident. It was during his funeral service that I discovered that by counting the 8 sides of the baptismal font in the front of the church over and over and over I could distract myself from the fact my father would never be in my life again. This helped to lessen my anxiety about how life would be without a father I adored.

My counting continued for many years and led to more OCD rituals. I began to compulsively read highway signs, store signs, etc and to always end the reading of the signs with a word that was a noun…not a verb or preposition which seemed to me to be active or changing and anxiety producing. I wanted to control my life and my emotions for fear of what catastrophic event might happen to me. The world felt like an insecure place.

At the age of 21, more OCD rituals began. After a traumatic relationship-related event I began to compulsively wash my hands, take long showers, and be concerned if my clothes were clean, if my house was clean and safe for others to enter, and to dwell on other contamination fears.

Although there is some controversy over how EMDR works, my therapist believes EMDR works by moving the trauma (memory) from the amygdala (fight-flight or worry circuit of the brain) to the hippocampus part of the brain where it can be processed and released. Brain integration takes place as new neural pathways are created and distress is relieved. I no longer get thoughts stuck in my brain, replaying them over and over and over again.

(Continued on page 12)

EMDR Therapy
(Continued from page 11)

EMDR activates the two hemispheres of the brain similar to REM sleep which is characterized by rapid back and forth movement of the eyes. REM sleep enables emotional processing. EMDR enables emotional processing at an extremely fast speed.

Since EMDR therapy, I have about 30% of the amount of anxiety I experienced most of my lifetime and it has made my OCD symptoms decrease and life much more pleasurable for me.

When people think of PTSD and EMDR they usually think of treatment for war veterans but EMDR is also used to treat victims of sexual assault, crime, automobile accidents, natural disasters, critical parents, complicated grief, phobias, pain disorders, eating disorders, panic attacks, emotional and physical abuse, addictions, body dysmorphic disorders, performance anxiety, and people with dissociative disorders.

To learn move about EMDR I recommend the book ***Getting Past Your Past***, by psychologist Francine Shapiro, PhD. Dr. Shapiro discovered EMDR in 1987, and in 1989 she reported success using EMDR to treat trauma in an issue of the ***Journal of Traumatic Stress***.

Also if you go to the EMDR International Association website, emdria.org (or call 512-451-5200) or go the EMDR Institute website, emdr.com (or call 831-761-1040) you can search for a trained EMDR specialist in your community.

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

Words of Wisdom

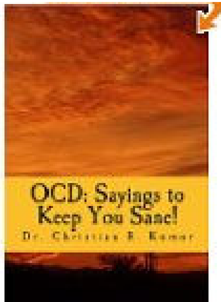
When you change the way you look at things, the things you look at change. - Dr. Wayne Dyer

Feel the fear and do it anyway. - Susan Jeffers

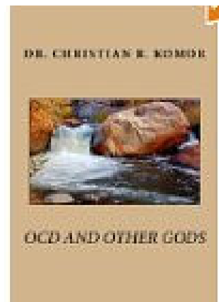
Change your thoughts and you change your world.
- Norman Vincent Peale

SUGGESTED READING

This month's "Suggested Reading" books are all authored by a member of The OCD Foundation of Michigan Scientific Advisory Board, Dr. Christian R. Komor, a clinical psychologist who treats OCD. Dr. Komor has written numerous articles on OCD and many books on OCD and other topics. All of Dr. Komor's books are available from amazon.com. Search: Books: Dr. Christian R. Komor. (The books are listed here in descending order of date of publication.)

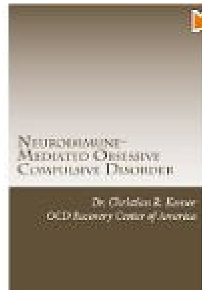


Dr. Christian R. Komor
OCD: Sayings to Keep You Sane: Reminders, Affirmations & Slogans, CreateSpace Independent Publishing Platform, 2013
ISBN: 978-1484038673

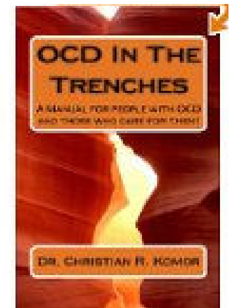


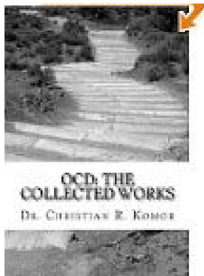
Dr. Christian R. Komor
OCD and Other Gods
CenterSpace Independent Publishing Platform, 2008
ISBN 978-1478277118.

Dr. Christian R. Komor
Neuroimmune Mediated Obsessive Compulsive Disorder
CreateSpace Independent Publishing Platform, 2012
ISBN: 978-1478285359

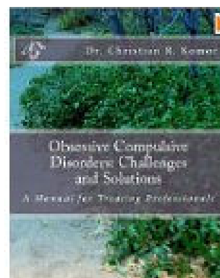


Dr. Christian R. Komor
OCD in the Trenches
CreateSpaces Independent Publishing Platform, 2006
ISBN 978-1478274414.



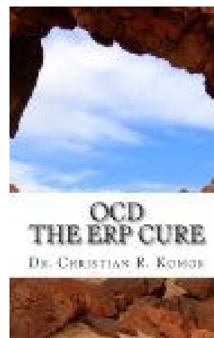


Dr. Christian R. Komor
OCD: The Collected Works
CreateSpace Independent Publishing Platform, 2012
ISBN: 978-1478309765.



Dr. Christian R. Komor
Obsessive Compulsive Disorders: Challenge And Solutions—A Manual for Practitioners
CreateSpace Independent Publishing Platform, 2004
ISBN 978-1478302544

Dr. Christian R. Komor
OCD: The ERP Cure: 5 Principles and 5 Steps to Turning Off OCD,
CreateSpace Independent Publishing Platform, 2012
ISBN 978-1478330578



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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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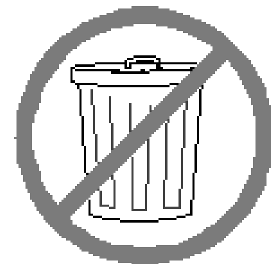
Please Don't Throw Me Away



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.

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